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THE MODERN HOSPITAL

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A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.

VOL. XXXVI *May, 1931* NUMBER 5

When Will the Hospital Be Suitably Paid for the Industrial Case?

By HOWARD S. CULLMAN

President, Beekman Street Hospital, New York City

THE problem of restoring to health and strength the victims of industrial injuries is to a great extent a hospital problem.

In urban communities, at least, it cannot be denied that the hospital looms large in the care of all accident cases. It is the hospital ambulance that hastens to the scene of disaster, the intern who either administers first aid at once or brings his patient to his institution for bed care. On the wards, the hospital provides all necessary surgical and medical attention with their concomitants of nursing, drugs and other diagnostic and therapeutic measures; nor is the patient dismissed until arrangements for after care and follow-up have been made. It is, I believe, no exaggeration to maintain that without hospitals, private or municipal, the great bulk of our industrial accidents could not be in any way adequately handled.

Such being the fact, it would appear self-evident that fair dealing and cooperation with hospitals are imperative to the proper functioning of the New York State workmen's compensation act. It is due to the willful disregard of this truth on the part of numerous insurance companies that many abuses have crept into the administration of this law which was designed primarily for the purpose of shifting the cost of industrial mishaps from philanthropic groups to industry itself. It was to have been, in theory, the means of elevating the injured workman from the status of a helpless pauper to a self-respecting individual, insured against accident and able to pay his own way in case of illness or disability. Curiously enough, however, insofar as the hospital is concerned, the industrial accident case remains what it always has been, an indigent patient, a drain on the hospital's resources.

A Wrong Use of Hospital Funds

The proof of this lies in a simple set of figures. The companies carrying workmen's compensation insurance will pay the hospital a maximum of $4.50 a day for bed patients. The average cost of a ward patient in a private hospital in New York City is $7 a day. The resultant deficit has in the past been covered by hospital funds intended for needy cases. That this is not a fitting use of money donated for the destitute is apparent; that it is directly contrary to the spirit of our compensation law, in permitting the pauperization of injured workmen, must also be clear; that it places a grave and unnecessary financial burden upon the institution treating compensation cases, anyone familiar with the matter will testify.

Nor is it only in its wards that unwarranted demands are made on the hospital's generosity.

Many industrial cases receive full treatment at the scene of accident. For such services no charge is rendered. Yet their cumulative cost to the hospital is considerable, and one that cannot be regarded as a legitimate part of an institution's necessary philanthropies.

Coupled with these obvious injustices is the equally trying custom of insurance companies of delaying payment for hospital services. The assumption that it is a hospital's duty to wait many months until its just fees have been adjusted and paid, is groundless. There is no valid reason why the costs of hospitalization should not be met not only fully but promptly by the insurance companies.

These difficulties have been partially corrected by New York City municipal hospitals, but through the dubious agency of a further injustice. It is the custom in these institutions to appropriate for hospital expenses, surgical fees collected for compensation cases. Obviously, it is unfair to physicians, upon whom there are already too many demands for free services, to cover hospital bills at their expense. Nor are such makeshifts necessary. It is not at the sacrifice of medical men's fees that these costs should be met, but by the companies carrying insurance designated for that purpose. If present premiums are inadequate they should be raised; but industry must assume full responsibility for its injured if the compensation act is to have any significance. It is not only in its financial aspects that hospitals have found the compensation situation troublesome. Numerous stumbling blocks, nonpecuniary in nature, lie in the path of the institution endeavoring to dispense the best of medical treatment to all its patients and it is difficult to overcome these obstacles. Chief of these is the ever growing practice of lifting cases from private institutions to commercial clinics. Trading upon the ignorance of their clients, insurance companies frequently transfer them to their own clinics on the pretext of checking up on their progress. Here the patients receive treatment that is cheaper for the insurance companies, but often far inferior in quality to that dispensed by the private hospital they have left, where the best in medical care is the practice. This tendency, to treat compensation cases in commercial clinics, is to be deplored. The underlying motive, of economizing on human health, is incompatible with the high standard of treatment that the injured workman merits. It is the duty of hospitals to protest illicit attempts to dispense commercialized treatment, to warn patients of their legal rights.

Howard S. Cullman is one of the foremost exponents of social insurance for industrial accidents in America and has earned the right to speak with authority on this subject. He is one of the Commissioners of the Port of New York Authority, a trustee of the Flower Hospital and of the United Hospital Fund, chairman of the Bureau on Homeless, vice-president of the City Club of New York and director of the Lenox Hill Neighborhood Association Boys' Club and Jewish Social Service Association.

Mr. Cullman is one of the prime movers in the hospital committee on workmen's compensation insurance, which has undertaken a study of existing conditions for the purpose of recommending adequate changes in the workmen's compensation laws of New York State.

No discussion of compensation would be complete without mention of the insurance adjuster who still stands as a menace to a fair deal to the injured workman, and whose function is to try to shave and chisel any and all bills from physicians and surgeons as well as from hospitals. Through the activities of these adjusters, many of our better physicians and surgeons, as well as institutions, have been discouraged from handling workmen's compensation cases. Just as the hospitals waged war on ambulance chasing lawyers, I believe they should endeavor to combat the insurance adjuster.

It is in the hope of correcting many of these abuses that the private hospital committee on workmen's compensation was formed. It is the hope of this group that constructive legislation and an educational campaign will prove the means of restoring to our compensation act its rightful function so that industry will bear its rightful burden.

A Hospital Animated by the Spirit of Interracial Cooperation

By H. A. CALLIS, M.D.
Howard University, Washington, D. C.,
and
CLYDE D. FROST, M.D.
The Julius Rosenwald Fund, Chicago

PROVIDENT HOSPITAL, Baltimore, has become an outstanding example of a well run, well equipped hospital, managed and operated by members of the Negro race.

Founded in 1894 by six Negro physicians to provide hospital facilities, primarily for paying patients, it struggled along for the first eight years in an old residence on Orchard Street, with only ten beds. At the end of this period the hospital was transferred to two residences on Biddle Street and the number of beds ultimately increased to forty. These two projects were financed by the founders and were open to the Negro physicians of the city. The only source of revenue other than limited payments from patients was an allowance of $3.50 a week from the city for each free patient who was a resident of Baltimore.

For more than twenty years the hospital thus led a poverty stricken existence with inadequate facilities and limited opportunities for professional attainment by its staff. In 1920 a group of five leading white citizens and five trustees of the hospital first presented their cause to the public, with no great financial success. Five years later this group of trustees was increased to eleven. Their first efforts were directed toward reorganization and toward raising the standards of both hospital and professional services. In December, 1927, a public campaign for funds was organized and brought a most gratifying response from Baltimore. A total of $442,000 was subscribed, although the original goal had been only $150,000. In addition, John D. Rockefeller, Jr. and Julius Rosenwald each subscribed $25,000 in cash toward the building fund and $30,000 to be paid over five years on a decreasing scale for maintenance. As a result, the building formerly occupied by the Union Protestant Infirmary, on a main but not noisy thoroughfare in the Negro residential section of the city, was purchased and remodeled.

To-day the hospital is a modern five-story, brick structure of fireproof construction. The units are well planned, both the arrangement and equipment being conducive to efficiency and ease in handling patients. The business offices, the out-patient department and the emergency ward are all on the first floor. The out-patient department has a separate entrance but its lobby is connected with the main hospital lobby through an archway. The ambulance entrance to the emergency is at the rear.

The main kitchen, diet kitchen and the dining rooms for staff and employees are in the basement, as well as the engine room, maintenance rooms, laundry and pharmacy. The engineer and his staff take care of all painting, mechanical and electrical repairs without outside labor. The wards are situated in the south wing of each floor and the private rooms occupy the north, opening off a central lobby which serves as a visitors' lounge. There are porches off the wards on each floor. The operating rooms are on the top floor.

Several rooms originally intended for private patients have been turned over to the use of the

interns. Both private rooms and wards are bright and airy, and the private rooms are attractively furnished. Beds are available for 120 patients and there are nine bassinets. The male and female wards have sixteen beds each. There are also a sixteen-bed children's ward and an isolation ward for children. Most of the twenty-one private rooms are single. A few are planned to take care of two patients. The operating room is excellently equipped and well lighted. An installation of storage batteries provides for emergency lighting.

The hospital is incorporated as a nonprofit organization with these purposes: (a) providing adequate medical and hospital service, (b) training physicians and nurses and (c) fostering mutual respect and cooperation between Negro and white physicians.

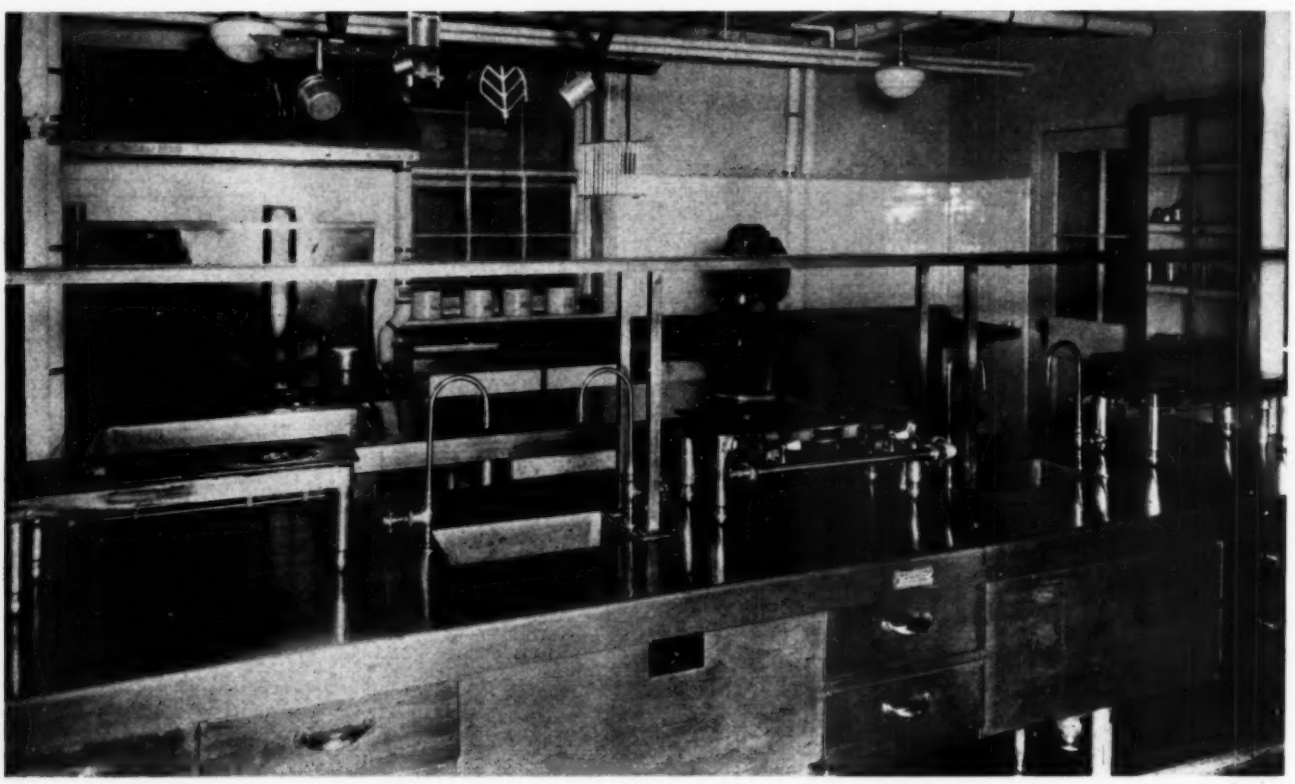
How the Hospital Is Managed

The present board of trustees is made up of eleven Negro men and women, representative of the business and professional Negro group in Baltimore. One of the members is a physician. These trustees are aided by an advisory board of ten white men, two of whom are physicians and one a hospital administrator. Full responsibility for the professional services of the hospital has been delegated by the trustees to a medical advisory board, composed of five white physicians. Two of these physicians are associated with Johns Hopkins University and two with the University of Maryland. Dr. J. M. T. Finney is chairman. This medical advisory board has been an active and effective body and keeps closely in touch with hospital affairs.

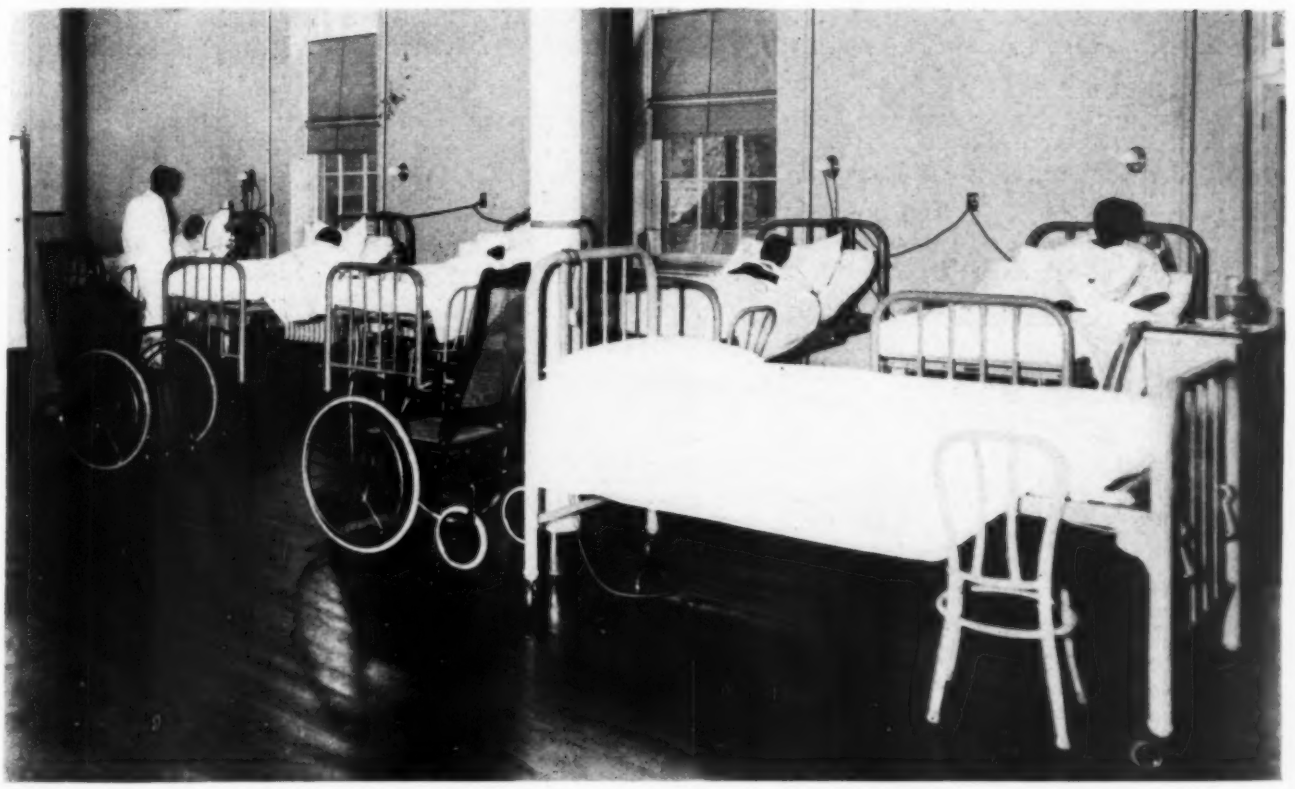
Four white physicians, two from Johns Hopkins and two from the University of Maryland, are appointed as supervisors and clinical teachers in the out-patient department in the medical and surgical services respectively. Shortly after the reorganization, sixteen Negro physicians with years of experience in private practice were appointed to the visiting courtesy staff, which implies privileges for treating private patients in the hospital.

On February 1, 1931, thirteen Negro physicians completed the first year on the out-patient department staff and were appointed to the visiting staff of the hospital, with privilege of private patients. Responsibility for ward supervision in medicine and surgery will be delegated to members of this group for unit periods of time. There are at present nine colored physicians assigned to the out-patient department. One junior consultant surgeon who has completed five years in the hospital as resident, two of which were after the reorganization, has recently gone into private practice in Baltimore and has been accorded full operative privileges in the hospital.

One senior resident, three residents (one each in medicine, surgery and obstetrics) and seven interns constitute the house staff. The post of resident pathologist is at present vacant. The interns



Floor diet kitchens supply the patients' food wants at Provident Hospital, Baltimore.



Professional service of high quality is provided Baltimore Negroes in this hospital operated by members of their own race. A fourteen-bed ward for men is shown here.

are appointed yearly and rotate through medicine, surgery, pediatrics and the emergency service. Intern appointments are made by the medical board on the basis of scholastic record. Informal daily ward rounds are made by the consultant and the respective service staffs. These are supplemented by formal rounds twice weekly. Pathological conferences are held monthly. Interns participate in autopsies and present case histories at the conferences.

Free Discussion Is Encouraged

All ward rounds and conferences are open to the medical profession. Free and open discussion of cases both in rounds and in conferences are encouraged and suggest mutual respect and regard among the whole professional group. Regular monthly meetings of the house staff are utilized for review of cases admitted and discharged during the month and for official completion of case records by confirmation of diagnosis and signature of the senior resident.

During the first year, case conferences or seminars, presided over by members of the medical board, were held. These conferences were also open to the medical profession. The attendance was variable, but ten physicians were sufficiently interested to attend every clinic. The largest number at any meeting was thirty-eight.

Patients referred to the hospital by a physician are referred back to him at the time of discharge. Notification is also given him of the time of operation and he is welcome to attend if he desires. Operative reports and clinical findings with recommendations are sent him at the time of the patient's discharge.

The superintendent of the hospital is a colored layman whose previous experience was in the field of business. He has had the benefit of close supervision by and the opportunity for training under one member of the advisory board, who is superintendent of the University of Maryland Hospital and who serves as consulting superintendent to the Provident Hospital. Through him both Johns Hopkins and the University of Maryland have extended privileges for observation and contact in hospital administrative matters for both superintendent and students in administration. One Negro student has just completed a four-months' period of observation and practice in hospital administration. A second will begin in the near future, and a third will follow.

Superintendent Establishes Rates

The admitting officer is a graduate nurse who is responsible only to the hospital administration. All rates are established by the superintendent. The assistant superintendent of nurses is responsible for the housekeeping. The esprit de corps of the department heads is good. The various units

appear to work together with perfect harmony.

The x-ray department is manned by a trained technician on full time. Professional supervision and responsibility are delegated to a clinician who checks and confirms all roentgenological diagnoses. The laboratory is so organized, equipped and manned that requirements of the American College of Surgeons and the American Medical Association are fulfilled. Technical work is done by a trained technician under supervision of the clinical pathologist.

A Well Organized Nursing Service

The nursing staff consists of a superintendent, an assistant superintendent, one night supervisor and a supervisor of each of the following services: operating, obstetrics, pediatrics, medicine and surgery. At present senior students of exceptional ability are assigned to the supervision of male surgery. Nine graduate nurses, three of whom are alumnae, are in charge of ward units.

Fifty undergraduate students in nursing constitute the maximum number admitted and this number is held constant by admissions each year to balance the number graduated. Theoretical and practical nursing and dietetics are taught by the departments represented, and the medical subjects by the resident staff. The use of maids, orderlies and ward janitors facilitates the work of the nurses in the wards.

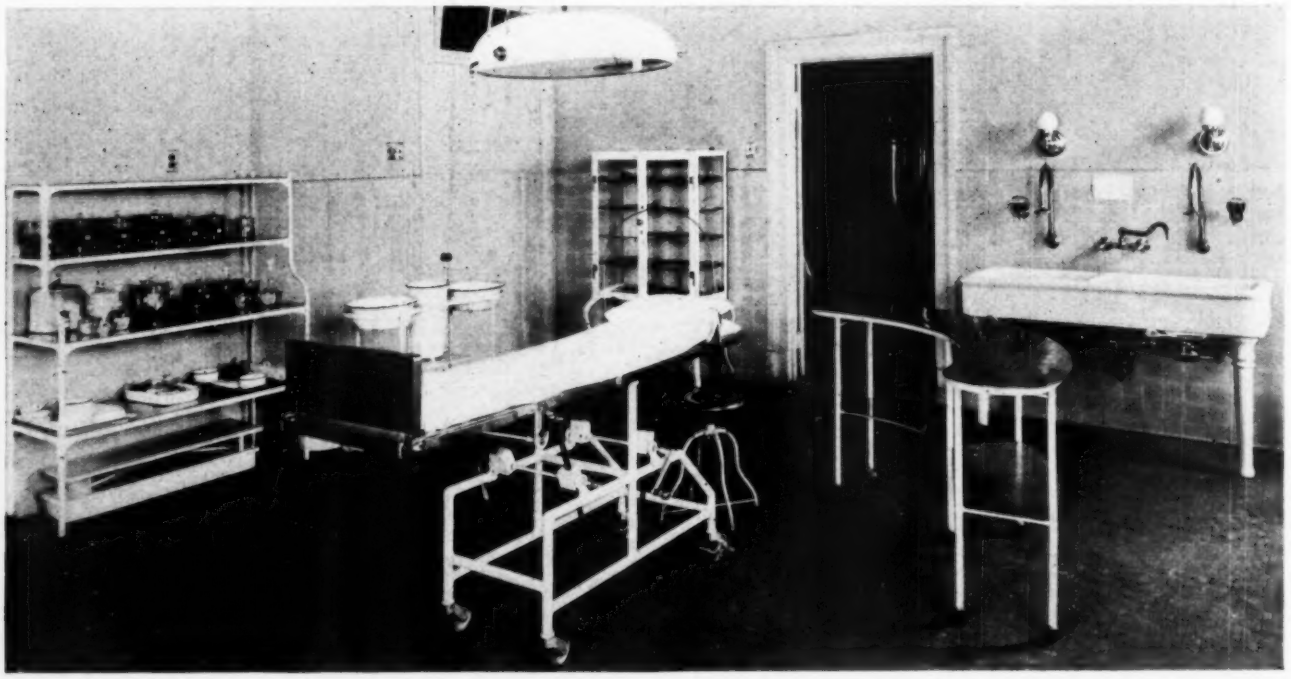
The services available at the hospital include medicine, surgery, obstetrics, gynecology, pediatrics, urology and orthopedics. Consultation service is provided in eye and in ear, nose and throat cases. All contagious and tuberculous cases are referred to other institutions, with which there exist cordial and cooperative relations. All admissions to the hospital are made on the recommendation of the senior resident. The unit record system for out-patient department and hospital is in use.

During the first year after the reorganization, 1,551 patients were admitted to the hospital and during the second year, 1,608, an increase of 10 per cent. During the fiscal year ending September 30, 1930, 159 cases were referred by outside physicians, 244 by staff physicians and five from the out-patient department.

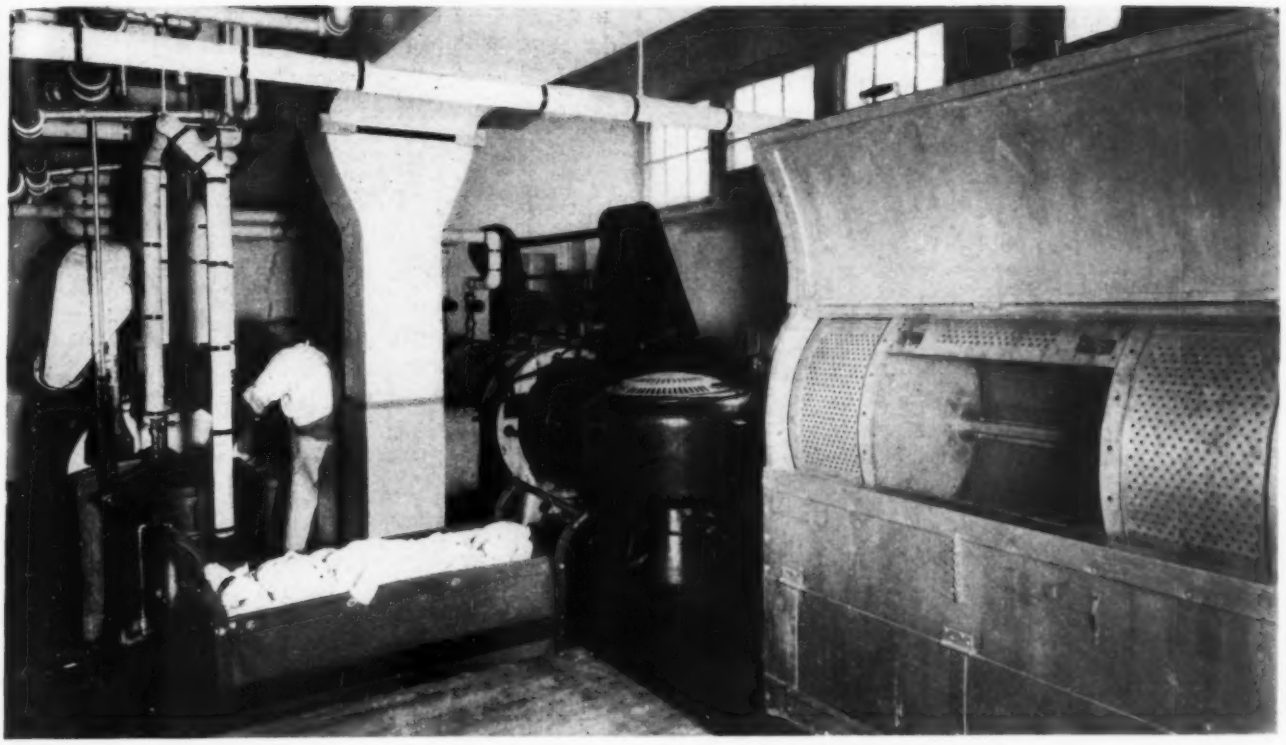
Days of treatment numbered 25,040 in 1929 and 29,900 in 1930. These figures represent an occupancy rate of 52.67 and 65.6 respectively. During 1930, 43 per cent of the days of treatment were rendered in surgery, 26 per cent in medicine, 10 per cent in pediatrics, 7 per cent in obstetrics and 6 per cent in gynecology.

The out-patient department service at present is limited to medicine and surgery, the latter including gynecology. This limitation is practically enforced by the restricted space available and is a definite disadvantage. All cases in need of other services are transferred to other institutions. The admission fee is twenty-five cents. The physicians who completed the first year of service on January 31, 1931, unanimously commended the plan and expressed the need for extension of services, both for physicians' training and to augment the holding power of the clinic.

Because of its location, the hospital carries on an active emergency service. The intern assigned



The operating room is well equipped and well lighted, and has additional storage batteries for emergency lighting.



The hospital's laundry work is done within the building in a department equipped with the newest and most efficient laundry machinery.

to this service also does dressings for surgical cases after discharge from the hospital. During the two-year period ending October 1, 1930, 4,703 patients were treated in the emergency department. Two hundred and seventy-three of these were admitted to the hospital.

The hospital rates are $2.50 a day for wards, $3 to $3.50 for semiprivate rooms and $5 to $6 for private rooms. Operating and delivery room charges are $5 each and the anesthetic rate is $5. A flat laboratory fee of $1 for wards and $2 for private and semiprivate patients is charged, while the x-ray rates are graduated according to accommodation utilized. The private rates for x-ray compare favorably with other hospitals and private laboratories.

Growth Is Marked

During the year ending December 31, 1930, approximately 32 per cent of patient days of service was rendered to full-pay patients, 66 per cent to free, and approximately 1 per cent to part-pay patients. The total days of treatment for 1930 were 29,900 and for 1929, 25,040, or an average of 18 and 16 days respectively for each patient. The 1929 per diem cost was $4.37 and for 1930, $3.75. This marked decrease was largely due to an increase of 3,860 days of treatment.

The Negroes in Baltimore number over 140,000. It is conservatively estimated that over 40 per cent of them use the services of fifty Negro physicians. Yet until recently opportunities for training in Baltimore in the medical and surgical specialties were not available to Negro physicians. Provident Hospital was reorganized largely for the purpose of giving Negro physicians such opportunities and of providing satisfactory hospital facilities for those of the Negro population of Baltimore who wished to continue under the care of physicians of their own race.

An Institution of High Standards

After the reorganization a number of Negro physicians were dissatisfied and in some cases resentful. Of the various factors responsible for their feeling, the following are significant: the delay in extending hospital privileges to them; certain misunderstandings that arose in connection with the appointment of the Negro attending staff; the unprofessional attitudes of certain interns; difficulties in the admission of patients, especially part-pay patients; and the fact that the opportunities for association between the attending and consulting staffs were too few. It seems evident that these physicians did not appreciate the fact that the new Provident Hospital could be established firmly and acceptable standards maintained only through the gratuitous service of physicians whose clinical opportunities and hospital experience had been obtained in first-rate institutions, regardless of color.

But the dissatisfaction and resentment are dis-

appearing. A survey was recently made of the professional relationship of the Provident Hospital to the physicians and laity of the community it serves. Negro physicians, both those who are at present on the hospital's attending staff and those who are not, trustees and others discussed the situation freely. The strong impression gained by the survey was that a number of physicians who had been opposed, or even bitter, were now anxious to see Provident Hospital firmly established and were referring more patients there and that they would be willing to refer still more patients as soon as they felt that the obstacles which had been in their way were completely overcome.

The consulting staff and the university members of the medical board are deeply interested in the development and maintenance of the Provident Hospital as an institution of high standards for the service of Negro physicians and their patients. The trustees are cognizant of the social significance to Baltimore of the successful operation of Provident Hospital as a biracial institution in which Negro patients may receive the best hospital care. Every effort within their means and consistent with good standards is being made by both trustees and medical board to serve better the profession and the public. The increase in the number of admissions to the hospital is evidence of the increase in public favor and a recognition of its high standard of service.

At the time the hospital building was remodeled, those in authority determined to spend all the money necessary on equipment, furnishing and construction, to make the hospital not only "good enough" but as good as any institution of its size and type could possibly be, irrespective of race connection. As a result, adequate hospital facilities and professional service of a high quality are now available to the Negroes of Baltimore in a hospital managed and operated by members of their own race.

Cafeteria Owners Urged to Await Outcome of Waldman Case

Within the past thirty days many hospitals have received letters asking that they pay patent royalties for the use of a tray slide in their cafeterias.

Advice from attorneys for cafeteria owners is to the effect that at the present such payment be withheld until a case now pending has been finally settled.

Following are excerpts from a letter recently mailed out by the Food Service Equipment Association:

"Those who operate cafeterias are seeking advice about a circular letter of March 18, 1931, received from the 'Mapleton Corporation'—which is the latest name adoption of the patent promoters following a recent shift in ownership. This letter renews the earlier demands of a 'settlement' with them for a license to operate under the old Weston claims of 1916.

"As the national Food Service Equipment defense committee is convinced these claims will not hold when finally tested in the U. S. Courts, it is advised that communications be ignored but that all future demands be reported both to the equipment firm and to this office.

"The Piccadilly decree—which this letter cites as proof of soundness of their claims—is not recognized by the industry, for in that case those who were entrusted with the defense chose to rely on the U. S. Playing Card Company's use, a prior use example where there were neither trays nor a slide or track; and they failed to reveal to the court all the genuine evidence known and available proving that common use of the cafeteria predates Weston's 1909 application by at least two years. This evidence is now in our hands.

"The Miami case, which was not named but also cited in the same letter appears to be that of the Mapleton Corporation *versus* Holesome Cafeteria, Inc., 956-M-Eq.—where there was no defense. Usually a defendant takes his twenty days allowed him by law in which to prepare and file his answer to the bill of complaint and ninety days to prepare for trial. But, without reporting that he was being sued or offering to cooperate with those who could have helped him defend himself, this defendant chose to consent to a judgment against himself. Such types of cases can establish no precedent of validity.

"This letter also does not mention the fact that in Denver their bill of complaint failed to force the Waldman Cafeteria to consent to a settlement arrangement. Instead, able patent counsel has been engaged and D. M. Waldman has filed a complete answer. Soon at the trial the promoters will be required to test their claims in the face of our complete array of prior use evidence. We regard this as the first case in the country where a complete defense will have been presented. Those who have studied our evidence, expect the court will be justified in ruling that their claims are invalid.

"In the meantime, thousands of cafeterias will continue to receive impressive circular letters demanding that they pay out good money now, before the Waldman case comes to trial—without offering guarantees of a refund of all monies paid them if and when the claims are invalidated."

How Trained Anesthetists Improve Hospital Service

By RALPH M. HUESTON
Superintendent, Silver Cross Hospital, Joliet, Ill.

BOARDS of trustees and medical staffs that are seeking better ways to serve their patients are organizing departments of anesthesia on a similar plan with the departments of clinical pathology and of roentgenology.

Instead of broadening and becoming more general, the field of anesthesia has narrowed to the degree that it is highly specialized. The many advancements in the several branches of anesthesia have created a demand for specialists in this work. As a whole, doctors are recognizing the importance of trained anesthetists. In many hospitals, the doctors are not only recommending but are demanding a department of anesthesia.

In the smaller hospitals where the volume of surgery is too limited to justify employing a full-time anesthetist, combination positions can be arranged. Such combinations as anesthetist and historian or anesthetist and technician are not uncommon. Sometimes these combinations make it possible for the hospital to maintain two or more part-time departments.

Once a department of anesthesia is organized and the doctors have experienced the advantages of the services of a trained anesthetist, it is easy to develop the department. One hospital reports that it maintains a department with one full-time anesthetist on the receipts from an average of 100 operations a month. Another hospital reports that it maintains a department with one full-time anesthetist and one part-time anesthetist on the receipts from an average of 175 operations a month. A third hospital, where the staff doctors demand a trained anesthetist in the birthroom for every birth, reports that it has two full-time anesthetists for an average of 150 operations and thirty-five births a month.

Paying the Anesthetist

The average salary for the nurse anesthetist seems to be between $125 and $150 a month with maintenance. When the anesthetist is a doctor, the salary scale is much higher. In some hospitals the doctor anesthetist works on a commission basis.

The anesthetist must possess skill and must be experienced in the use of the different anesthetics and the various kinds of anesthetic appliances. The cooperation of the patient should be solicited to aid the anesthetist in the selection of the anesthetic or the combination of anesthetics. Alcoholics, excessive smokers and extremely nervous patients require added consideration in the selection and administration of an anesthetic. If the patient is suffering from a kidney complication, an anesthetic that would not irritate this organ should be chosen. If a patient has acute rhinitis or an elevation in temperature or shows evidence of pulmonary tuberculosis or has recently had bronchitis, the operation is usually postponed. If the patient's condition is of such a nature that an operation must be performed under adverse circumstances an anesthetic that will least aggravate the existing conditions should be selected.

Putting the Patient's Interests First

There are many advantages in having the patient who is scheduled for major surgery enter the hospital the afternoon or evening before the operation. One of the advantages is that by reviewing the patient's history and the reports of the various clinical examinations the anesthetist has a better opportunity to determine the type of anesthetic to be administered.

When time permits the anesthetist should visit the patient before the operation, especially if the patient is a child. This gives the anesthetist a chance to gain the friendship and win the confidence of the patient. Many times the results of the anesthesia and sometimes the results of the operation are materially helped by these visits. Following the operation, the anesthetist should accompany the patient from the operating room to the patient's room and should report his condition to the nurse in charge of postoperative care.

The administration of preliminary medication is of great value to both patient and anesthetist. It aids the anesthetist in maintaining an even depth of anesthesia. The amount of premedication given

is governed by the patient's physical condition, habits, size and age. The anesthetist must be familiar with the effects of the various hypnotics. He should select the anesthetic to be administered, with the patient's condition and welfare in mind.

An ideal anesthetic causes the patient only the slightest unpleasantness during induction, affords a sufficient depth of anesthesia for operations to be performed and produces the minimum injurious effects on body functions and the least postoperative discomfort. Nitrous oxide-ethylene oxygen anesthetics come nearer fulfilling this ideal than any other. To administer this type of anesthetic properly requires extensive study and training. The study includes not only the signs and effects of the anesthetic but the manipulation of the machines with which it is administered. The mixture of the gases is governed by the needs of the patient. This is determined by the anesthetist. Gases are difficult to handle so as to maintain a mixture that will keep the muscles in the desired state of relaxation for an indefinite time.

When properly administered, the effects of gas anesthetics on the body functions are found to be slight. Gas anesthetics are pleasant to take. This is of special importance, because with the use of gas the patient has no unpleasant recollections to cause a rebellion should another operation be necessary. The induction period in nitrous oxide and ethylene anesthesia is short and the patient has no sensation of choking. This type of anesthesia differs greatly from the prolonged, unpleasant induction of ether. In gas-oxygen anesthesia, muscles retain their normal tone, which is desirable for the postoperative welfare of the patient. This anesthetic does not produce the muscular relaxation obtained with ether. Surgeons working with gas-oxygen anesthesia will develop a habitual gentleness in the handling of tissue and in the use of retractors and sponges. This, too, is for the patient's ultimate welfare. In major abdominal surgery, where more marked relaxation is desired, an infiltration of the more sensitive tissues with procaine hydrochloride will often give the desired effect. If under certain existing conditions relaxation cannot be attained with gas-oxygen, rather than permit the patient to become cyanotic ether should be added.

When a Gas Anesthetic Is Used

Because of the rapidity with which nitrous oxide and ethylene produce results and the rapidity with which the gas is eliminated, it is more difficult to retain an even level of anesthesia when they are used and therefore more skill and experience are required to administer a satisfactory gas anesthetic than an ether anesthetic.

Not only the rate of the pulse but also the pressure and rhythm must be watched. The history, examination and diagnosis made prior to the operation will aid the anesthetist in knowing what to expect from a heart and what to be prepared for. A sphygmomanometer should be employed and the blood pressure determined frequently. Under anesthesia any change in pulse rate or blood pressure is significant and requires immediate interpretation. Many lives have been lost from shock which might have been saved by early diagnosis and appropriate treatment. The anesthetist must understand the action of the different stimulants to determine the condition under which they are indicated. During operations in which there is a probability of circulatory disturbance, a chart should be kept showing the observation of pulse rate and blood pressure taken at frequent intervals.

Recognizing Important Signs

The anesthetist cannot overestimate the value of the signs of respiration. No anesthetic can be successfully used without efficient breathing. Patients with short thick necks and those with large tongues have difficulty in breathing during anesthesia. The creation of an airway will often remedy this condition. The anesthetist can aid the surgeon in operations that involve the trachea and laryngeal nerves by watching the respirations and informing him of any disturbance.

The value of carbon dioxide should be recognized by the anesthetist. Unsatisfactory breathing is often noticed following premedication. If this is too marked, it can be corrected by adding carbon dioxide to the anesthetic. If the machine is not equipped with carbon dioxide, the gas can be accumulated by rebreathing. This will stimulate the respiratory center and produce deeper respirations. In light anesthesia cessation of breathing may occur because of the patient's holding his breath and it may occur in profound anesthesia because of spasm of the respiratory muscles. In each case, oxygen must be forced into the lungs.

The anesthetist must be familiar with eye signs, as they are valuable in determining the plane of narcosis.

Although gas-oxygen is difficult to administer, the anesthetist has a feeling of satisfaction upon seeing a patient who has been under the influence of this anesthetic, no matter for how long, awaken immediately after the anesthetic is discontinued.

Complications following gas-oxygen anesthesia are appreciably less than after other anesthesias. The discomforts caused by gas-oxygen are few.

If administered properly, the anesthetic should be just a pleasant memory to the patient.

The Importance of Training Hospital Employees

By LOUIS J. FRANK
Executive Director, Beth Israel Hospital, New York City

FROM time to time we hear the story of a wag who takes special delight in telephoning to some hospital and inquiring as to the condition of a fictitious patient. It is really an old gag. Nevertheless, whenever an occasional answer from a careless clerk declares that "the patient is resting comfortably," it never fails to delight the trickster.

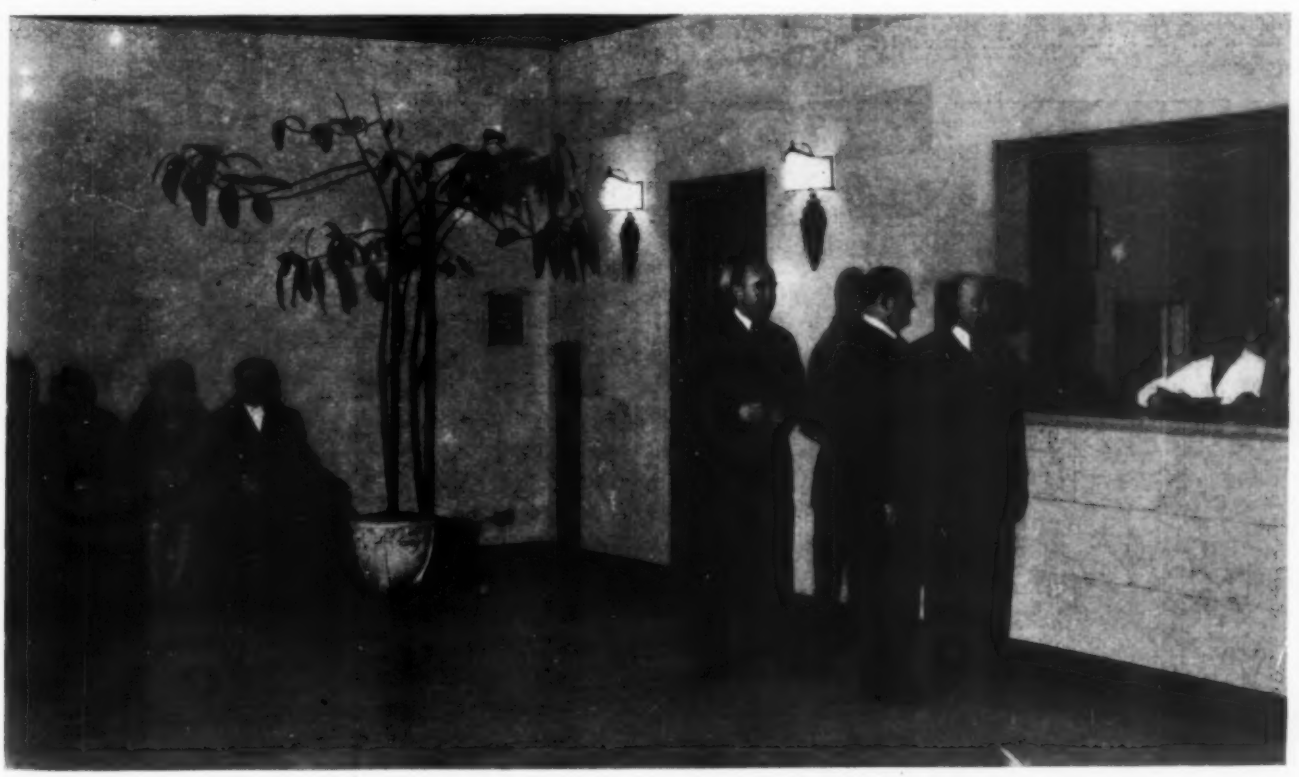
This presumption of incompetence in hospital clerks is a vestige of the old aversion toward hospitals, a relic of the days when only those without a friend or relative in the world and perhaps the very poor and moribund went to a hospital; of the days of ancient poorhouses where occasionally a patient received medication and where clerks and superintendents were modeled after the uncivil and slothful characters in Dickens' stories of English poorhouses and the way they were managed.

Not so long ago hospitals used to make it a habit to employ persons who had proved failures in other lines. It seemed to be axiomatic that a handicapped or slow-witted person would eventually wind up with a salaried position in an "institution." Directors and politicians thought little of referring to hospitals those who could not fit into any other organization.

Standards Are Being Raised

Fortunately the public's conception of hospital clerks' ineptitude and indolence has been considerably changed. Directors of institutions are beginning to realize their obligations to employ persons of a high type.

All of us no doubt have in our institutions clerks upon whom we can depend in any sort of emergency. These hospital-minded employees, thoroughly familiar with the mechanism of the institution, have taught us to depend upon them



Courteous employees at the admission counter make the patient's first hospital contact easy.

with a confidence that must ease the load upon the shoulders of every superintendent. Almost invariably these employees are imbued with conscientiousness and love of their work.

In a former article,[1] I spoke about the responsibility of a superintendent to the house staff and the responsibility of the house staff to the superintendent. In this paper I propose to discuss the responsibility of the hospital to the employees and the responsibility of the employees to the hospital.

Sometimes we are blind to the fact that often crucial situations in the structure of the hospital organization depend upon the intelligence and diplomacy of the clerk. Often problems of undue proportion arise as the result of some slip in the handling of a patient's visitors or relatives, made by the clerk who is acting, whether he realizes it or not, as a direct representative of the hospital.

Working in a hospital is a unique experience and special psychologic factors are involved. Yet few of us take this into account. We see to it that the employees are instructed in their routine duties and neglect to train them in regard to these very psychologic factors that are so important. Do we ever take the trouble to point out to them the inherent differences between the function of a hospital and the function of a business organization? How much, except superficially, do we tell them of the attitude they should adopt toward the patient? Young medical men spend years trying to find out the best methods of handling patients, only to realize after a while that each patient is an individual problem and requires individual approach. And yet we take it for granted that clerks will pick these things up as a matter of course. How much do we ever tell the new clerk of the inner mechanism of the institution? Yet this information is an important part of a hospital employee's equipment.

Do we explain to employees the social aspect of their tasks and the fact that employment in a hospital entails not only the efficiency demanded in a business organization but also the use of a social sense? Often clerks who in one sense perform their work efficiently are of a type who should not be in a hospital because of their limited understanding of the nature and function of a philanthropic and scientific institution. We find that working in an institution has transformed these clerks into hardened, tactless and unsympathetic individuals, who show an indifference to the feelings of relatives and patients that would be considered shocking and callous in a surgeon or physician of many years' standing. No one who cannot display a sympathetic interest in his work should be retained. Sullen clerks should be discharged immediately. One of the most important characteristics of the clerk should be a pleasant and confidence-inspiring appearance. If this is lacking, no amount of efficiency can compensate for it.

Since hospital employees have an unusual type of position, special consideration and instruction should be given them. I suggest that hospitals employing a large number of clerks should institute classes for their instruction, where there will

[1] Frank, Louis J., What the Superintendent and the Intern Owe to Each Other, THE MODERN HOSPITAL, August, 1930, vol. 35, p. 89.

Frequent meetings at which the executive director confers with the heads of the various hospital departments are a valuable means of maintaining the employees' interest and promoting their welfare.

A social service worker interviewing an applicant for admission should display not only a sympathetic consideration for the patient's individual needs but also a calm patient interest in the questions he asks.

be discussed in organized fashion at regularly established sessions the entire problem of the approach of a clerk to the patient and to the public. By this I mean not only instruction in the social amenities (by no means unimportant) or lectures on the need of a sympathetic consideration of the individual requirements of each patient (these are no longer as necessary in contemporary hospitals as they were twenty years ago), I mean also appropriate lectures on the significance of the hospital and its obligations to the community and an explanation of why the directors of the institution and the community support it, so that, knowing the policy of the institution, the clerks may grasp the social significance of their positions and conduct themselves with proper dignity and helpfulness. We spend considerable time thinking of how to convert the public into a hospital-minded community. What about our clerks whose very duties make them valuable missionaries for this work?

In these classes there should be stressed the importance of a calm patient interest in the distress of each bewildered relative as he comes to the desk, and instruction should be given as to how questions put by visitors should be answered and which questions should be referred to the proper authorities. Clerks should not be allowed to use their imaginations in answering questions, and the instruction should take the form of routine questions and answers so that the reply a visitor receives in answer to a question put to one clerk will agree with the reply he may receive when the same question is put to a different clerk on a different floor. This is an important problem and I suggest that a group of hypothetical questions that might come up in the routine of their duties be put to a group of clerks. The difference in the answers will be startling if not amusing.

It is important also to see that some organized action be taken to avoid the circulation of individual ideas, freely dispensed by well meaning clerks. We should discourage the imaginative ingenuity displayed in thinking up an answer for any question. No business organization making any pretense to good standing and efficiency would allow such a procedure and certainly no hospital should.

These instructions should not cover merely the white collar workers; elevator runners, hall men and all others coming in contact with the public should be included. All should be familiar with the physical layout of the building as well as with the function of each department. Before the workers are assigned to their tasks, full instructions should be given to them. Then they should be put to work with someone who is familiar with the institution and who can watch them and render reliable reports as to the character of their service during a probationary period. This is perhaps a cumbersome procedure but certainly it is an important one and it warrants all the inconvenience.

The courses of instruction should not present great obstacles. Half an hour a week devoted to them would be more than sufficient. It might also be advisable to have booklets printed, containing a resumé of the lectures so that the value of the work will not be lost as the years lapse and constant replacements occur in the clerical force.

It is surprising how much responsibility even the most menial clerk possesses and how much of

an opportunity for development is possible with each position. The position is important from the point of view of giving correct directions and correct information and also from the point of view of dealing tactfully with the bereaved relatives of a patient. The employees should be impressed with the importance of a knowledge of hospital routine, visiting days, surgical days, rounds, meetings being held in the building, conferences and the manner of interviewing important visitors.

tion in providing medical care for their families, assignments for regular medical examinations and attention and, of course, the fundamental requirements—comfortable housing accommodations if the employees live in the hospital—and palatable food.

Every institution should be a training school for hospital executives and just as the medical man takes pride in having trained a younger man to carry on his work, so every hospital superintendent

This picture shows a well trained employee conscientiously interviewing the bewildered relatives of a patient.

A hospital is extremely proud of the character of its teaching and of the training afforded interns. It should be no less proud of the educational opportunities in hospital management afforded employees and of the fact that executive positions are filled by employees who have been trained in the institution. If we expect all this from our employees, it is our duty to do everything possible to maintain their interest and to promote their welfare. Among the things that help to attract a desirable type of employee are insurance, prospective pensions, entertainment (if the hospital is in an isolated neighborhood), special consideration in providing medical care for their families, assignments for regular medical examinations and attention and, of course, the fundamental requirements—comfortable housing accommodations if the employees live in the hospital—and palatable food.

Every institution should be a training school for hospital executives and just as the medical man takes pride in having trained a younger man to carry on his work, so every hospital superintendent should take pride in the number of men he has developed. It should be the goal of every superintendent to train younger men and women who after a certain period will be in a position to take charge of other institutions.

Whether we like it or not, we must face the fact that the members of the public will often judge an institution by the way in which they are received when they visit there, and unless we have a well disciplined intelligent and genial force and a friendly relation between executives and employees the initial impression of visitors to the hospital will not be favorable.

State Health Insurance as It Affects Hospital Finance

By C. H. GIBBONS

Secretary, Royal Commission on State Health Insurance and Maternity Benefits, Victoria, B. C.

THROUGHOUT British Columbia there has been evinced an overwhelming opinion that a system of public insurance against losses by illness should be devised and applied without delay. This insurance would not only protect the interests of persons of limited means but would also effect economies in provincial and hospital services. It would be a step toward the reduction of the costs of medical care; it would protect the hospitals against bad debts, and it would aid in scientifically reducing preventable sickness and in building up a healthier, happier and more progressive community.

"There is no dissenting opinion, even on the part of life insurance managers, that government insurance has resulted in far-reaching reforms, that it has been of vast benefit to the people, and that it has come to stay," says Frederick L. Hoffman, an American insurance expert, while Dr. Michael M. Davis, director of medical service, the Julius Rosenwald Fund, Chicago, has stated that "in the fact that sickness and its costs are unevenly distributed lies the necessity for applying the insurance method of protecting wage earners more particularly. There is no substitute for social insurance in economically distributing the costs of illness."

Why Voluntary Insurance Does Not Meet the Need

At the same time careful study of the character and scope of the various schemes of health insurance obtaining in Great Britain and advanced foreign countries, and of the evolutionary changes made in such schemes, leads to the conclusion that to be effective any plan of state health insurance must be compulsory. Voluntary insurance against sickness is now and long has been available in Canada through the enterprise of private insurance companies, fraternal societies and labor organizations. Our own national experience has demonstrated that the very classes and individuals who have most to lose through interruption of their regular employment by sickness, and who are financially least able to bear the cost of sickness, are those who constitutionally take no thought of the morrow and are content to let their more provident fellow citizens not only provide against the possibility of sickness in their own homes, but make up the deficits in doctors' and hospital bills created by the neglect of such improvident ones.

The conclusion may safely be drawn that the British Columbia Commission on state health insurance now functioning will in reporting to the legislature at its next session recommend for the general public interest the enactment of a compulsory system of public health insurance, devised to meet the special conditions of this province of vast distances, scattered population centers, struggling farming and fruit growing interests and industry founding pioneers of the hinterlands. The British Columbia state health insurance problem in these respects is individual, and the method of meeting it must not be a copy or an adaptation of methods that have proved successful in older countries.

Industry Also Will Benefit

It is to be noted also, on the evidence of the commission's research work thus far accomplished, that provincial opinion as to state health insurance has materially changed during the past few years, with more general study and fuller understanding of the subject. Ten or even five years ago the common if unconsidered opinion of industrial and general business interests was that state health insurance in operation would be merely another example of paternalistic legislation for the special advantage of certain classes of workers, further adding to the operating changes of already overtaxed industries. The conclusion of the majority of such business interests now is that whatever fair proportion of necessary premium charges employers may be called upon to shoulder will be offset by benefits to the industries as well as to the workers.

Municipal corporations of British Columbia are found to be 100 per cent in favor of state insurance against sickness losses, and the members of the Canadian Manufacturers' Association in this province, hitherto inexorably opposed to state health insurance proposals, have now by a ten to one majority endorsed the initiation of a practical

scheme in such connection. The earlier disposition was to accept as axiomatic the fact that if employers were to contribute to the costs of health insurance protection for their workers overhead expenses inevitably would be increased. Such an attitude seems to overlook or ignore the following facts:

By its general application on actuarial principles a wider spread of insurance should reduce the average cost to below that now possible under existing voluntary employees' benefit association schemes.

Administration costs of such services will be eliminated.

Equities now missing in the operations of competing interests will be assured, to the marked advantage of employer bodies actively interested in the welfare of their workers.

Employers will gain by decreased interruption of the sustained capacity efforts of their working forces. This will be effected through betterment of health standards, anticipating and preventing the development of illness, enhanced general efficiency born of relief from workers' worry, and extension of the span of activity for experienced employees.

Reduction of abnormal charges now carried by the province and by municipalities in connection with health protection and care of the sick, aid for hospitals and physicians' subsidies through a considerable proportion of such charges being assumed by established insurance funds, will in turn be reflected in reduced taxation now indirectly borne by industrials.

A major portion of the sickness costs now placed upon the province and municipalities through nonpayment of hospital charges will be wiped out, such charges being made 100 per cent collectible by the health insurance machinery.

There is, too, a growing appreciation by the heads of important business interests of the dollars and cents advantage of doing everything humanly possible to maintain industrial workers in full health and fitness, not as humanitarianism or benevolent charity but as essentially sound business policy.

What Other Countries Are Doing

Early in the present commission's investigations, when analysis was undertaken of every piece of state health insurance legislation and every concrete proposal in that connection the world over, it became clear that the provincial position in regard to the proposed legislation was unique in that all prevailing forms of state health insurance legislation are in a measure inapplicable because such legislation is universally national, not state or provincial.

Great Britain has its national insurance system, which has so functioned, despite some natural defects, as to lead the chief medical officer of the British ministry to testify that "the value of health insurance practice is beyond all question." The Irish Free State has a like system. The Union of South Africa is taking steps in the same direction. Australia is moving similarly, the states of the commonwealth rejecting as impossible of consideration the suggestion that such protection for citizens of limited means should be other than national. In Canada the consensus is identical—that there should be public health insurance and that such insurance should be a Dominion obligation and a Dominion responsibility.

This has been emphasized on the one hand before the parliamentary select standing committee on industrial relations by President Tom Moore of the Trades and Labor Congress of Canada, representing the employees' class, and on the other hand by Mr. Coulter for the Canadian Manufacturers' Association, speaking for the employer body. These men are agreed that any state health insurance scheme should preferably be Dominionwide, else the business interests of participating provinces might conceivably be penalized in competition with like business interests of nonparticipating provinces, much as certain Ontario business interests, the garment trade more particularly, are penalized by the operation of a minimum wage law that is nonexistent in Quebec.

The Ruling of the Department of Justice

The department of justice maintains, however, and its ruling is insisted upon by the Dominion as final, that jurisdiction in all such legislation rests exclusively in the provinces, by virtue of the British North America Act, which is Canada's great charter, although it would admittedly be within the constitutional right of the Dominion parliament to make grants from the national treasury to the provinces or any of them, as partnership contributions in financing, should state contribution to costs be made a factor in any adopted provincial health insurance scheme.

The former federal minister of labor, the Hon. Mr. Heenan, voiced the attitude of the Dominion government of which he was a member in saying that "the Dominion should wait for the provinces to take the initiative." It was also pointed out by the federal committee that British Columbia had given such a lead in this suggested new social legislation, as in the somewhat parallel old age pensions law.

The Dominion is now committed to the principle of state health insurance through the unanimous adoption by the government and by the parliament of the portion of its committee's report

relating to this matter. The committee, however, found its inquiries handicapped by inability to secure authoritative data on the extent and costs of sickness in Canada, the nonavailability of any concrete project upon which actuaries could prepare statistical information, and the infrequency of helpful census compilations. As a result of this the recommendations have been adopted at Ottawa that a comprehensive survey of the field of public health activities be made with special reference to a national health program, and that in the 1931 census, provision should be made for securing the fullest possible data as to the extent of sickness and sickness costs, presumably with a view to Dominion action.

The Dominion is committed to the initiation of such a Canadawide health survey, and to making proposals for state health insurance a matter for consideration at the next Dominion-provincial conference. It is therefore reasonable to hope that in the development of whatever form of health insurance the British Columbia legislature in its wisdom may enact, in the event of this providing for state contribution to costs the Dominion will assume such charges in whole or in part, although this could not be expected in advance of information obtainable as a result of the census.

It is assuredly high time that the nation's legislators took steps for the reduction of the national sickness charge, now placed at more than $311,000,000 annually, and for decreasing medical and hospital costs. Such sickness costs and the economic loss to Canada are placed by one student of the situation at no less than from two-thirds to three-fourths of the total expenditure of the Dominion. Canada's hospital upkeep bill exceeds two hundred and fifty million dollars annually and is steadily mounting and the yearly loss of future earnings through preventable deaths has been placed at the enormous total of one billion dollars, with 2 per cent of the population constantly ill, 50 per cent of this illness preventable, and at least 35 per cent of our deaths each year preventable by intelligent protection of the health of the people.

How Insurance Will Help

How are reductions of these costs and losses to be affected by the application of state health insurance? Primarily, by giving heed to the lessons of state health insurance practice in other countries and by a systematic revision of health services with primary attention to keeping the people well. Sir Arbuthnot Lane urges that the medical profession reorganize its principles and its policy with this objective in view. Dr. W. S. Rankin, director of the Duke Foundation, declares that "the insurance principle appears to be the only remedy, but a most effective one, for providing adequate medical care for a large percentage of the people." And Mr. Woodsworth, M.P., has told the Canadian House of Commons that "under a thoroughly organized national system of state health insurance there would be many economies; there would be much preventive work that would naturally lessen the bills, and yet on the other hand there would be much more extensive and thorough service than can now be provided."

While the science of healing has been making tremendous strides, the business of healing has lagged woefully behind. Economists and industrialists are becoming more and more impressed with the necessity of checking the enormous economic waste caused by sickness. This is peculiarly a function of public health insurance machinery, and claims are advanced in Europe that the operation of compulsory health insurance has lengthened the normal employment life of industrial workers by from seven to seventeen years.

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500 Beds Set Aside for Emergency Cases Among Veterans

More than 500 beds in Army and Navy hospitals, under authorization of Brig. Gen. Frank T. Hines, administrator of veterans' affairs, will be allocated to the Veterans' Bureau for disabled veterans who may be admitted as "emergency cases," the bureau announced recently.

General Hines has taken this action upon the recommendation of Col. George E. Ijams, director, Veterans' Bureau, who reported that nearly all of the regional offices of the bureau have a waiting list of veterans who are in need of hospitalization. These additional allocations will be secured through the cooperation of the surgeon general of the Army and the surgeon general of the Navy.

It is expected that 100 additional beds will be secured at Fitzsimons General Hospital, Denver; 20 at Letterman General Hospital, San Francisco, and 50 at William Beaumont Hospital, El Paso, Tex., or a total of 170 beds in these various Army hospitals.

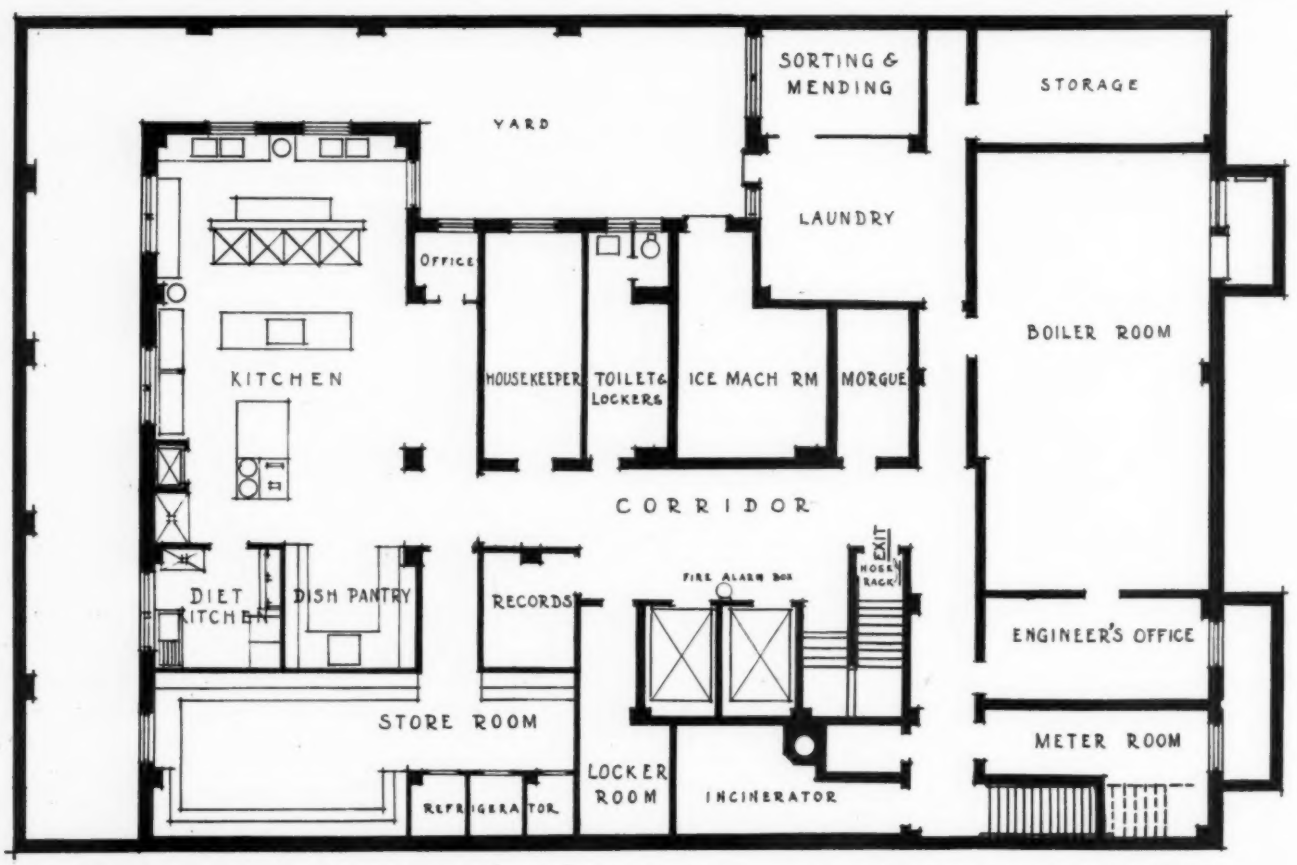
The surgeon general of the Navy will supply additional beds as follows: Brooklyn, N. Y., 50; Norfolk, Va., 50; Chelsea, Mass., 50; League Island, Pa., 25; Mare Island, Calif., 25; Newport, R. I., 50; Pensacola, Fla., 25; Puget Sound, Washington, 20; San Diego, Calif., 25; Washington, D. C., 25; or a total of 345 additional beds in Navy hospitals. It is expected that the allocation of these additional beds will greatly relieve the situation during the coming winter.

A Specially Planned Hospital for Special Needs

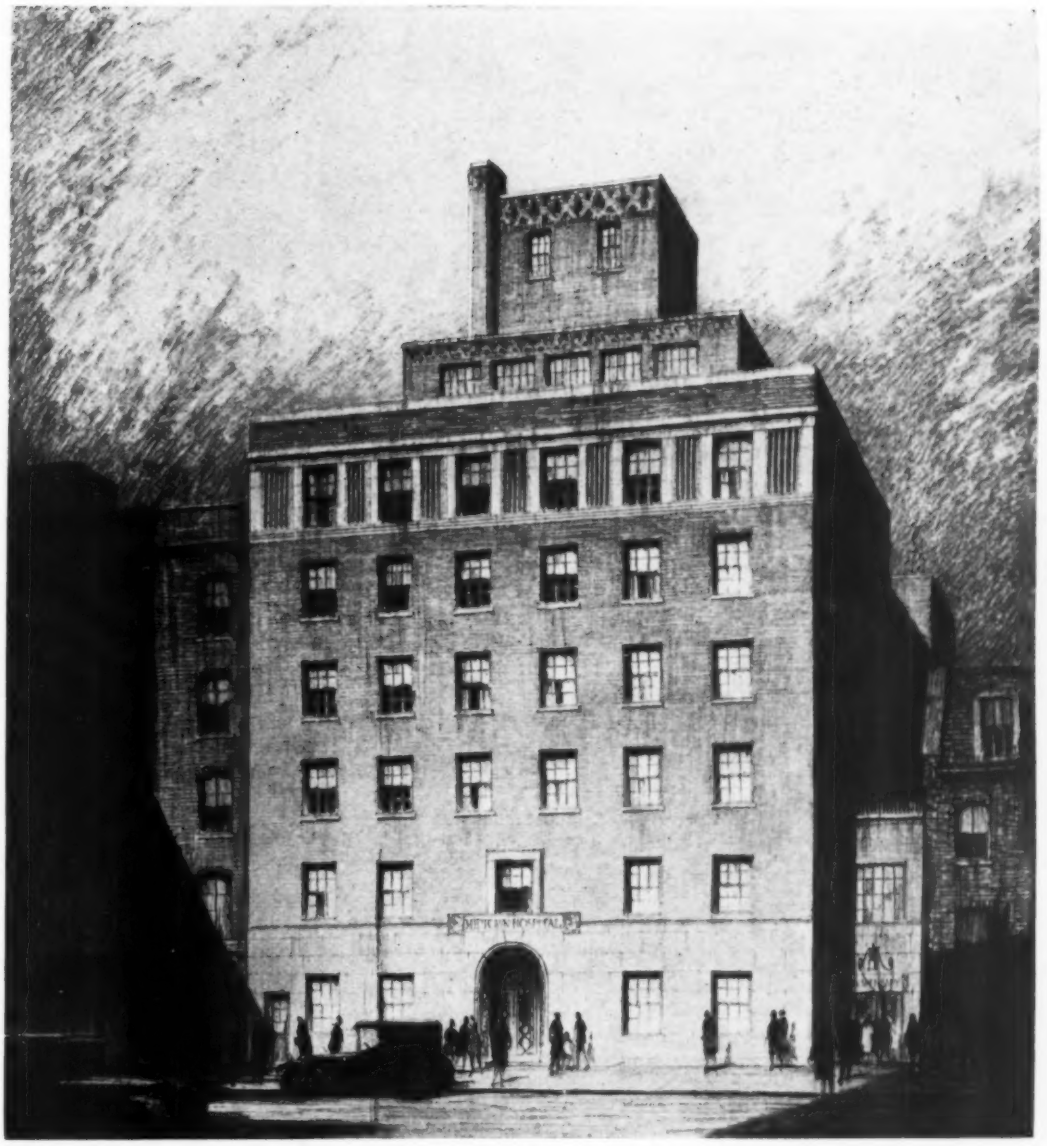
By EDWARD S. POPE, M.D.
Superintendent, Midtown Hospital, New York City, and
CHARLES BUTLER
Architect, New York City

IN RECENT years a general movement toward medical centers has been in progress. Existing hospitals have been consolidated for purposes of economy, teaching and research. These consolidations have been so extensive that they have resulted in a tendency to set out of balance medical service to the community at large. Midtown Hospital, New York City, recommended by Dr. Shirley W. Wynne, health commissioner of New York City, to maintain this balance, is the type of institution that is creating great interest throughout the larger cities.

Midtown hospital caters to three classes of patients: the private patients sent in by members of its staff, clinic patients and those admitted to the "industrial service." This latter is a radical departure from the usual method of clinic administration. Through it, we have been able to solve certain social problems that appear to be a matter of constant vexation both to the hospital management and to the medical profession. Through this service we have been able to standardize professional fees and hospital rates in such a manner that they are within the reach of persons of small means. We bring to that class of persons, often unable through lack of experience and medical judgment to select a suitable specialist for their trouble, the services of a highly qualified staff.



The basement is served by both elevators, by one main stairway and by a direct stairway from the street.



The extremely simple exterior of the Midtown Hospital is carried out in red brick, with brick pattern work on the top floor, the solarium and the elevator tower. The first floor is of limestone, and the main entrance richly decorated with carved stone.

This industrial service is limited to employees of business concerns who affiliate with the hospital. Such concerns are in a position to supply exact and accurate data as to the earning capacity and financial strain of prospective patients. A standard scale has been worked out for hospital rates and operative fees. The maximum hospital fee is less than the minimum fee in a specialist's office, as nearly as such standards can be worked out. When financial benefit accrues, the money is turned over to the doctors in charge of this clinic. We provide the patient with a service in which he is not used for teaching purposes. He passes only through the hands of skilled specialists, and ends with a check-up examination at the hands of his company doctor when he returns to work.

The hospital maintains a close contact with the company doctors, who in this way complete the guarantee that everything will check in regard to the welfare of the patient. An atmosphere of confidence and intimacy has developed between the hospital and the various organizations it serves. Much red tape and unnecessary loss of time are eliminated by our close contact with the organization doctors, personnel managers, social workers or whoever the contact agents may be.

It is not an easy matter to plan for the type and structure of one of these comparatively small hospitals. Every foot of space must be utilized and the needs of every department must be considered together with due allowance for their proportionate growth.

For those who are planning to build a similar institution, many useful ideas will no doubt be gained from a careful study of the accompanying description and plans. Several such ideas are here enumerated.

1. An architect of ability and imagination, with an earnest desire to produce the thing his client wants and needs, assisted by an able consultant.

2. The clinics and private pavilion controlled from a single office. This arrangement assures better organization with a more efficient and economical management. The clerical force is thus brought under the direct supervision of a single head.

3. All clinic hospital cases segregated on their own floor.

4. Dual elevator control allowing for operators by day and for self-service at night. Two elevators are necessary.

5. Ample provision for light and air all about the hospital together with the cross ventilation in the wards, the rooms and the corridors.

6. A special examining room for doctors to consult with an occasional case.

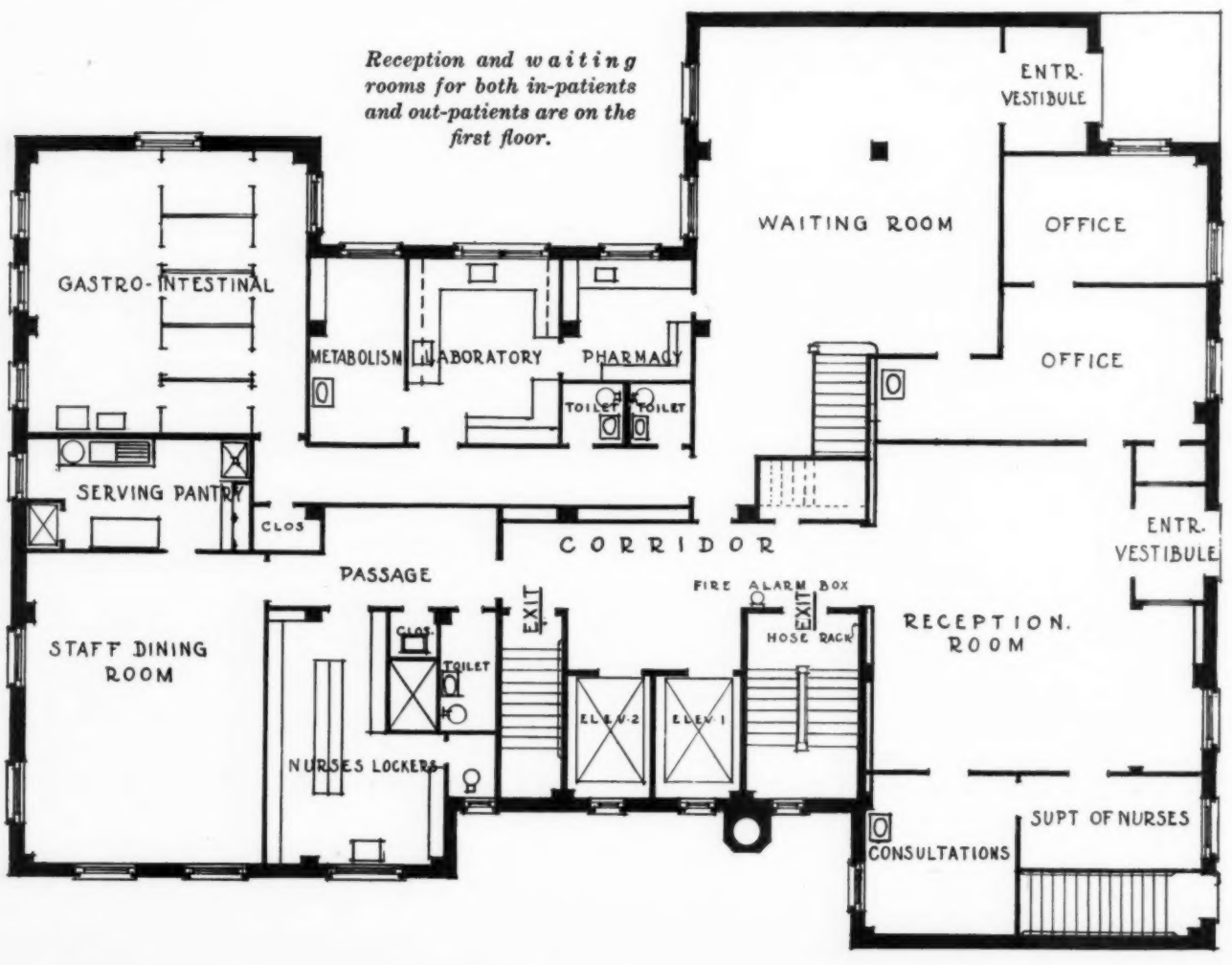
7. A solarium on the roof easily accessible to the patients.

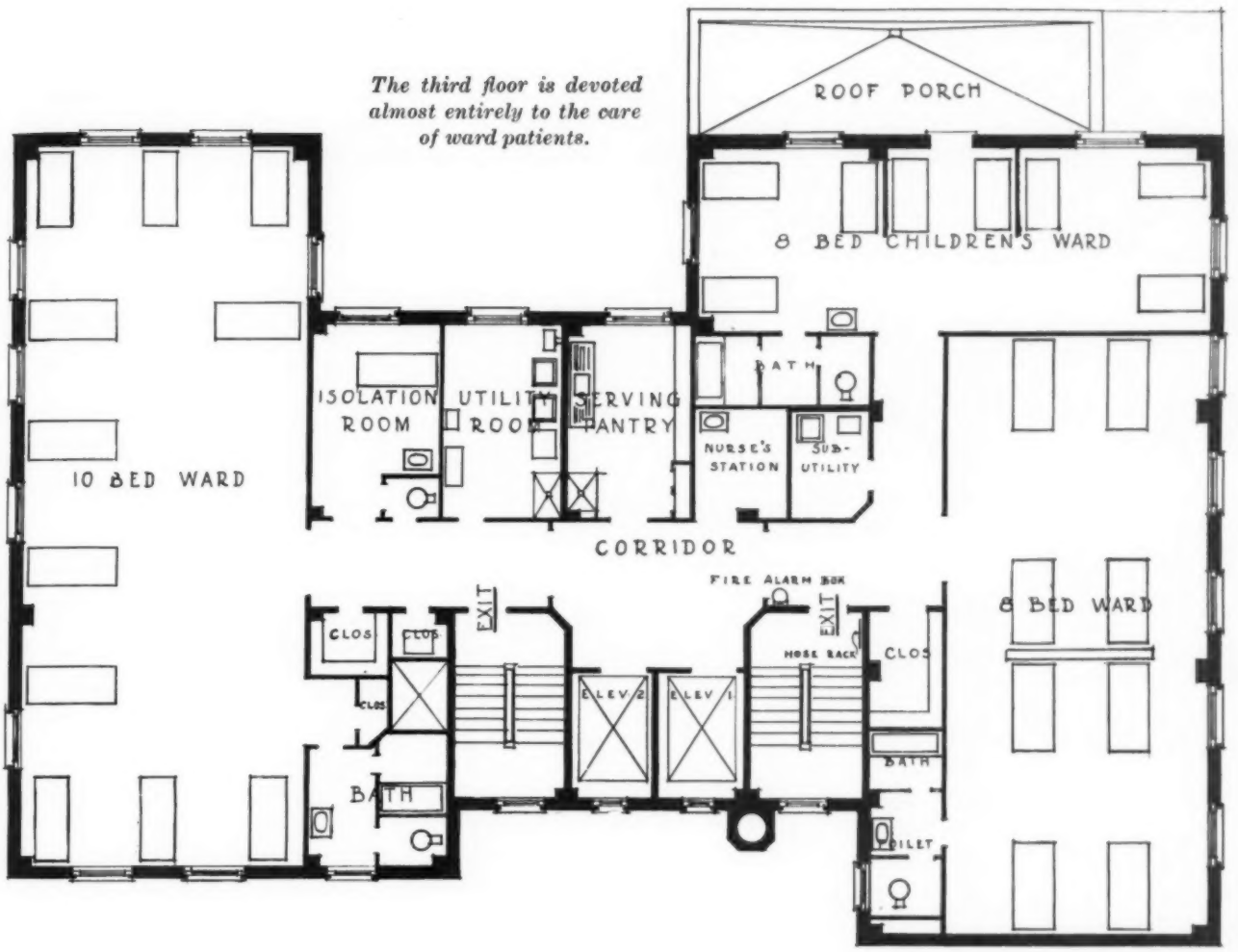
8. An arrangement for operating the telephone and attending the door at night to eliminate the salary of a night clerk.

9. An adequate call system for quick communication throughout the building. Under this heading is included a special bell system for checking the time of the nurse's answer to a bell; a signal system for communicating with the personnel throughout the building; a doctors' registry for checking whether a doctor is in or out of the building and telephone connections for intercommunication while the clerk is holding an outside call after the night connections have been made. All these promote rapid communication within the building, thus assuring greater efficiency and comfort.

Financing Plans

A word in regard to financing the building operations may not be amiss although these activities are probably well understood by the business members of hospital boards. The finance committee should be well organized and should plan for the requisite amount of cash to be on hand when various payments become due. To the professional man it may seem like "borrowing from Peter to pay Paul." There would appear to be two general methods: one to call upon the contractors and subcontractors to carry expenses by deferred payments until the building is completed and the other to have sufficient uninvested cash on hand to meet the several installments as they fall due.





The third floor is devoted almost entirely to the care of ward patients.

Failure to plan for payments in either of these ways is apt to be an expensive proposition for the hospital.

From our own experience, we should say it is impossible to discover ready made a set of plans to cover any one institution's particular needs. The details of the requirements of various institutions of necessity differ greatly. It was not until a contact had been formed between the architects and the hospital authorities that any practical progress was made. Not until there had been many consultations and conferences with the personnel of every department were the various ideas whipped into shape and the present hospital created.

The hospital as it now stands, represents a complete unit of the smaller type, well built and serving every need adequately.

The planning of the Midtown Hospital presented an interesting problem. To erect a hospital on a lot seventy feet in width between party walls and to provide accommodations for a greatly developed out-patient department and beds, mostly in private rooms, for sixty patients, with a large operating service, all in a six-story building and all with an ample amount of air and sunlight, was not an easy accomplishment.

The hospital committee was willing in order to accomplish this result to leave a ten-foot court on the east side extending through to the street at the third floor level. With the increased width of this court in the middle section and with the wide rear yard it has been possible to assure ample light to all sections of the building. We were even permitted to continue the west court, which lights the stairs and elevators to the rear yard through a narrow court, so that there is a free circulation of air around all parts of the building.

Architects who have had the experience of planning hospitals on inside lots will appreciate the attitude of the committee in sacrificing more space than is required by law, in order to increase the amount of sunlight and air.

The ground floor of the hospital is divided almost equally between the entrance vestibule and reception hall, the consultation room and the office of the superintendent of nurses, the stairs and elevators, the nurses' locker room and the staff dining room, all occupying the west half of the building. In the east half are the entrance for

out-patients, the large waiting room for this service, the pharmacy and laboratory, the metabolism room and the gastro-intestinal examination room, the latter divided into a number of cubicles. The two offices are placed between the two sections of the hospital, the public office being in contact with the in-patients' reception hall and the out-patients' waiting room. From the latter a special stairway leads to the second floor which is entirely given over to out-patients. Across the front of the building is the x-ray service with its offices, waiting room and dressing rooms and dark room while, adjacent to the main x-ray room is the genito-urinary service with an access door that makes possible the use of the x-ray machine for cystoscopic work. To the east are the dental operating and extraction rooms, and on the east court are the dental filling rooms. These rooms constitute an exceptionally efficient dental clinic.

In the rear the northeast corner is occupied by the eye service with its dark room. The northwest section contains a double ear, nose and throat service with a small clinic operating room between this group and the eye clinic. The ear, nose and throat rooms are provided with small individual treatment cubicles and are served by a common dark room. Throughout all these services, instrument sterilizers and clinical sinks are provided, while the more important sterilizers of the dental operating room are placed beneath a hood with exhaust ventilation.

Ample waiting spaces with benches are provided in connection with the various services on this floor and these are in contact with the elevators and the two main stairways which are required by the New York law and which continue up to the top of the building.

How the Third Floor Is Arranged

The third floor is devoted to the care of ward patients. Across the front (south) is the eight-bed women's ward, divided by a six-foot free standing partition into two units. The beds are placed parallel to the outside walls, with four beds placed with heads against the low partition. The toilet and bath are in direct connection with the ward and are lighted from the small west court. To the east of the women's ward and extending through from the street to the east court is the eight-bed children's ward. The roof of the ten-foot easterly section of the out-patient department serves as a terrace for the children's ward. It is thus possible to segregate the children from the adults who use the solarium on the main roof. A bath and toilet also adjoin this ward. The entire rear (north) portion is occupied by the men's ward planned for twelve beds, with toilet and bathroom. Adjoining this ward is a one-bed isolation or quiet room with toilet.

The general service rooms are grouped in the center of the building. Directly opposite the elevators is the serving pantry, equipped with refrigerators, a steam table, a sink and a dresser. As a precaution against fire and smoke the elevator lobby is separated from the stairs by self-closing fire doors, and these doors also serve to keep the noise of the elevator doors and the pantry from the ward units. The nurses' station also opens into this lobby.

The main utility room is placed to the north and is equipped with instrument and utensil sterilizers, a bedpan sink, a wash tray and service sink, a blanket warmer and a refrigerator. To avoid the necessity of carrying bedpans from the south ward to this utility room, a small subutility room, containing only a bedpan sink, a service sink and a utensil sterilizer, is provided close to the women's and children's wards.

On each floor are a linen closet and a housemaid's sink closet.

It should be noted that the medicine cabinet with its small sink is placed in the nurses' station well out of the reach of patients.

Features of the Four Upper Stories

The fourth and fifth floors are alike. Each consists of private and semiprivate rooms with and without private baths, to meet the requirements of every purse. Across the front are six rooms with a southern exposure. Two of these have private baths and the four others are served by two baths, which may be used by both rooms or rented with either room. To the north of this group is a two-bed room with bath. The rear of the building contains four private rooms without baths and a three-bed semiprivate ward at the northeast corner. The arrangement of isolation room and service rooms on these floors is similar to that on the ward floor. Lavatories are provided in all rooms that are not in contact with baths.

The north half of the sixth floor is devoted to the main operating group. This consists of two major operating rooms with north light and with a sterilizing room and a workroom between. The large lobby giving access to these operating rooms contains the surgeons' scrub-up sinks, three in number, placed each in a stall formed by six-foot marble partitions. These two main operating rooms are the same size, 15 by 19 feet, with double windows 8 feet in width. The only fixed furniture in the operating rooms is a sink and an instrument sterilizer. The main sterilizing room contains the two dressing sterilizers, the water sterilizer, two utensil sterilizers and a blanket warmer. The

workroom contains the utensil cupboards and dressers, instrument washing sink and instrument cabinets. The anesthetizing room also opens into the main lobby.

South of the lobby are the two minor operating rooms, 12 by 14 feet and 13 by 14 feet, provided with ordinary windows only and planned for use with artificial light. The smaller of these rooms forms a part of the main group, while the larger placed directly opposite the elevators and separated by glazed fire doors from the rest of the service, may be utilized as an emergency operating room for out-patients. It is provided with a scrub-up sink in addition to the usual instrument sterilizer and service sink. To the south of this last operating room is a large supply closet.

The south portion of this floor, cut off from the operating unit, contains a room and bath for the housekeeper, a sitting room, a bedroom and bath with south and east exposures for the superintendent, a sitting room, two bedrooms and bath for two resident nurses, and two bedrooms and bath for the resident interns.

In the seventh floor penthouse is the solarium, 12 by 37 feet with a full southern exposure. It opens on to the terraced roof which surrounds it on the east, south and west. This terrace is floored with red tile and varies from ten to twelve feet in width with a total development of 100 feet. This area, protected by a brick parapet wall, forms an attractive and ample space for outdoor rest.

This floor contains also the board room, a private office for the doctors in charge and the necessary toilet and housemaid's sink room. The remainder of the enclosed space is occupied by the ventilating fan room, which exhausts the foul air from the toilet and bathrooms and from the kitchens, serving pantries and utility rooms, while a separate exhaust system ventilates the operating rooms.

This plan is typical of the fourth and fifth floors which are alike, and consist of private and semiprivate rooms.

The basement, which is served by both elevators, by the southerly of the two main stairs and by a direct stairway from the street, contains in the rear the main kitchen with its accessory rooms, the diet kitchen, the dish pantry and the main food storeroom with the main refrigerators.

Basement Rooms Are Well Lighted

The rear yard and the east court are carried down the full width so that these rooms are unusually well lighted and ventilated.

The ranges stand out in the open against a spur wall with the cook's table in front, while the sinks, the worktables, the butchers' bench and chopping block line the north and east walls. The tray table and dish heater with the urns, the egg

boiler and the toaster also stand free. Space is left on the south side for food truck storage, while a small office for the dietitian occupies the southeast corner.

The diet kitchen about ten feet square with refrigerator, range, sink and dresser is at the northeast end of the kitchen and adjoins the dish pantry which occupies a recess, separated from the kitchen proper by the soiled dish table.

Exterior Is Simple

The store room, 13½ by 34 feet, contains the usual shelving and counters and the three-section walk-in refrigerator. It is likewise well lighted.

The housekeeper's office adjoins the kitchen on the south, and beyond it are the locker room and toilet for the women help. Opposite these rooms is the record room and next to it, under the north stair which stops at the first floor level, are the locker room and the toilet and shower for the men help.

To the south of the women's locker room and separated from the rest of the basement, is the ice machine room, containing the refrigerating machine of the ammonia type, access to which is had only from the east yard. Adjacent to this and opposite the foot of the south stair is the small morgue required by law.

To the south of the morgue is a cross corridor, extending from the foot of the service stairs to the small laundry and mending room. The laundry is used only for hand work since the bulk of the work is sent out. This corridor also gives access to the boiler room, the engineer's office and the motor room and on the north to the fumigating closet and the incinerator room, which is placed under the west court, with skylight over. The building is heated by two oil burning low pressure steam boilers. The boiler room contains in addition the hot water tanks and the vacuum, oil and house pumps, while the oil storage tank is placed in the extreme east portion, cut off by a brick wall and buried in sand.

The exterior has been kept extremely simple in character. Above a first floor of limestone the mass of the building is of red brick, with brick pattern work on the top floor and on the solarium and elevator tower. There is a small amount of carved enrichment in connection with the main entrance, figures symbolizing medicine and research work appearing at either side above the entrance arch, while the motif is crowned by the head of Hygeia which is placed above the middle window of the second floor.[1]

[1]Architects for the new Midtown Hospital were Charles Butler, Clarence S. Stein and Frank E. Vitolo, Associated, New York City. Dr. Shirley W. Wynne, health commissioner of New York City, acted as consultant on many of the planning details.

Presbyterian Hospital Adopts Pension Plan

The Presbyterian Hospital, New York City, in cooperation with its staff of employees, has adopted a retirement and life insurance plan which will enable employees to retire at the age of sixty-five on a definite pension determined by length of service and previous annual income, it has been announced by Dean Sage, president of the hospital.

The Presbyterian, which operates also Sloane Hospital and Vanderbilt Clinic, is the first hospital in New York City and probably in the country to adopt a pension and group life insurance plan based on actuarial experience. The hospital is one of the member institutions of the United Hospital Fund.

The purpose of the plan, as explained by Mr. Sage, is to provide a pension at the age of sixty-five, an income in case of permanent total disability prior to the age of sixty, and generous life insurance protection for dependents. The plan is open to active employees of a year or more of service with the hospital.

The annual cost to the hospital is estimated as between $25,000 and $30,000. In addition, employees included in the plan are meeting their share of the cost through monthly payments amounting to 4½ per cent of their salaries. Employees who entered into the plan at the time of its adoption received credit for past service. In order to cover employees now approaching the retirement age, the hospital made a substantial lump sum payment.

What Social Services Cost Great Britain in One Year

The total cost of public social services in Great Britain during the last fiscal year was close to $2,000,000,000, according to a British report forwarded to the U. S. Department of Commerce by the trade commissioner at London. These services are administered under fourteen different acts or groups of acts of Parliament.

The fourteen different headings under which expenditures are shown include the various acts relating to unemployment, health, pensions, education, housing, reformatories, hospitals, lunacy and poor relief. The receipts from which such expenditures are made are derived partly from local taxes, partly from parliamentary grants and partly from other sources, such as contributions paid under various insurance and pensions acts.

How the Community Can Adequately Serve Its Chronic Sick

By ERNST P. BOAS, M.D.
New York City

DURING the past ten years interest in the chronic sick has become widespread, and to-day their problems are thrusting themselves on our attention with ever greater insistency.

There are several reasons for this. First, the chronic sick are seeking public relief in increasing numbers. Chronic diseases affect for the most part individuals of middle age and beyond, and with the increasing span of life, the older age groups in our population are steadily growing in numbers. Furthermore, there is a close relationship between dependency and lack of family. With the progressively diminishing birth rate, the loosening of family ties and the growing urbanization of our population many more of the sick are becoming charges of the community.

Once our eyes are opened, we see the chronic sick on every hand. Wherever we turn, as physicians, visiting nurses, hospital workers or poor relief administrators, the problems of this group are constantly clamoring for solution. The existing institutions, whether they are general hospitals, homes for the aged or for the incurable, or almshouses, all are compelled to grapple with the problem. Singlehanded they can find no solution and indeed can rarely minister to the needs of the individual chronic invalid. It is a hopeful sign that attention is being focused on this matter, for it is only by cooperative community planning that we may hope to achieve some measure of progress.

Problem Has Many Angles

Chronic patients present a difficult problem because their needs are so complex, because so many elements are concerned in their misfortunes. For their relief it is necessary to marshal not alone the medical but the economic and social resources of the community, for disease, poverty and maladjustment are inextricably interwoven in the web of circumstance that enmeshes such sufferers. In this respect, chronic diseases resemble tuberculosis and insanity, which indeed are but special forms of chronic disease that have been given particular attention because of the menace they present to organized society. It may be wise, therefore, to review what the community has done and is doing for the victims of these two disease groups in an attempt to discover how much of this program may be applied to the large undifferentiated mass of persons suffering from other chronic ailments.

How Mental Hygiene Movement Developed

From earliest times the mentally ill were placed in institutions, primarily, it is true, as a protection to society. At first no attention was paid to their medical needs. It was realized that with such long continued illness, families were rarely able to pay for the maintenance of the sick members, who had to be removed from the social group, so the community provided for their care, largely in almshouses.

Gradually we learned that these unfortunates merited more than bare custody. Beginning with the Utica State Hospital, Utica, N. Y., in 1843, a comprehensive system of state hospitals for the mentally ill was established. It was found that the patients were of several kinds: that some needed intensive medical and nursing care and that for others appropriate custodial care was adequate. In recent years greater emphasis has been placed on medical care and on early treatment and prophylaxis as well as on research into the causes of these disorders.

So we see the growth of the mental hygiene movement and the establishment of such institutions as the New York State Psychiatric Institute and Hospital. A significant feature of this development is that from the first it was realized that the care of the mentally ill was a proper charge on the organized community; that the individual families and the private relief associations were unable to handle the situation. Furthermore, the care of the mentally ill has been marked by an ever increasing intensification and differentiation of medical care.

The tuberculous, too, have in large part become a charge on the public funds. In this case, of course, the fact that tuberculosis is a menace to the public health served as the motivating factor.

The economic consequences of the disease, however, were probably equally potent in determining the establishment of the many public institutions for the care of its victims. The tuberculous are cared for largely in state, city and county institutions. And here, too, we see the gradual change from the offering of the crudest custody or domiciliary care to the establishment of true hospitals for the tuberculous. And recently, New York State has provided a certain subsidy to families whose wage earners are receiving sanatorium care.

Chronic sufferers will not receive a square deal until there is general acceptance of the fact that they too are a proper charge on the organized community and that it is necessary to apply intensive effort and enlightened study to the many problems involved in their care, as has been done in the case of the mentally ill and of the tuberculous.

Not every chronic invalid requires identical assistance and relief. In the past it has been assumed too readily that all chronic diseases are incurable, that those who are thus afflicted need receive no constructive treatment but that simple domiciliary care suffices for most of them. Thus most of them receive but the most elementary medical care, either in their homes or in a custodial institution, such as an almshouse or a home for incurables. Yet many of them need continuous and expert medical attention, which because of their physical disability and poverty can be given adequately only in an institution. This class is for the most part shamefully neglected.

Caring for Custodial Cases

There is another group of the chronic sick in whom the disease is arrested but who have been left with some serious physical disability which makes them dependent on others for assistance in dressing, eating, bathing and moving about, but who need no intensive care. These custodial cases can be cared for either in institutions or in their homes, depending on local circumstances. In our discussion we must keep these two groups of cases clearly in mind.

Let us first consider the custodial group, for in many ways their problems are simpler. With them social and economic factors are of greater significance than medical ones. Such an invalid may disrupt the home by the demands he makes upon the well members, and he may impair the family income by forcing a wage earner to stay at home to look after him. At best, with the utmost willingness of all concerned it is difficult in a poor home to provide him with the simple comforts and services he needs without placing undue hardships on the other members of the family. Yet placing such a person in an institution is not the only solution for the situation. After all it is the poverty of the home, a poverty that is all the graver if the invalid is the wage earner, that makes home care so difficult. The problems of such custodial patients are closely related to those of the dependent aged, and they may therefore be approached in the same way.

Financial Help Is Needed

Until recently the destitute aged were as a matter of course placed in almshouses and in homes for the aged, and the possibility of providing some other form of relief was ignored. To-day many believe that institutional care should be reserved for exceptional cases and that the majority of the needy aged should receive extra-institutional relief. Whether this should take the form of old age pensions or old age insurance is another matter.

The same point of view may be applied in the case of the chronic sick. Since it is chiefly lack of money that makes home care so difficult, some form of old age or invalidity pension might enable many of them to receive adequate care in their homes. The scope of such relief would be greatly widened by an extension of the visiting nurse system. While it is true that at present many chronic patients receive home care from visiting nurses, it is well known that often, because of the pressure of acute cases, this care is insufficient. This obtains particularly during certain seasons of the year when there is a great demand for the services of the visiting nurses. For many patients, women less highly trained than nurses, carefully supervised by graduate nurses, might provide valuable service at less cost.

Some such enlightened combination of a financial subsidy with an appropriate system of home nursing will satisfy the wants of many of those who need custodial care. However, there will still be many who need institutional care. Even when a disease is nonprogressive it may cause complete disability, necessitating many hours of nursing care a day and the administration of medicines and the various forms of physiotherapy. This as a rule can be carried out only in an institution. To the number of such patients must be added many in whom the disease is still active and who require continuous active medical attention. For the most of these institutional care is indispensable.

What Type of Institutional Care Is Needed?

It is pertinent, then, to inquire what kind of an institution will meet their needs.[1] At present, many types of institutions—homes for the aged, homes for incurables, almshouses, city or country in-

[1] Boas, E. P., and Michelson, L., The Challenge of Chronic Diseases, New York, The MacMillan Company, 1929.

firmaries and general hospitals—offer refuge to these unfortunates. They offer them refuge but little else. But those in whom disease is still active must have at their disposal all of the resources of a general hospital. Furthermore, such hospital care must be continued for months at a time. This is one of the reasons why the chronic sick are not welcomed by the general hospitals, for the average stay of a patient in a general hospital is but ten to fourteen days. The presence of many chronic patients would clog the service and prevent an adequate turnover. It is unnecessarily expensive. As a rule patients with chronic diseases, scattered through the wards of a general hospital, do not receive the special attention they need. Fundamental to adequate medical care for these invalids is an intelligent, hopeful point of view, a determination to leave no stone unturned that may give relief and a conviction that many can be radically helped.

How, then, are we to provide institutional care for these sufferers? There is no one answer. This care is conditioned by the size of the community and the available resources. In large cities separate hospitals for chronic diseases will yield the most satisfactory results. Such hospitals must have all of the facilities of general hospitals, that is, nurses, doctors, dietitians, laboratories, x-ray apparatus and the like. At the same time certain features peculiar to institutions giving long time care must be stressed, such as occupational therapy, entertainments and radio.

Attached to or as a part of such a hospital there must be a section for custodial cases to which patients whose conditions have sufficiently improved can be transferred and where they can be kept at less cost. There are great advantages in providing hospital and custodial care under one administration, for the medical condition of these patients changes frequently, and transfers from one section to another are often indicated. Such a well conducted hospital for chronic diseases gives the best service to its patients and offers opportunities for research as well as for teaching. But it is clear that its establishment is feasible only in large cities, where a hospital of 250 beds or more is needed.

A Chronic Not Counted an Interesting "Case"

Smaller communities can make provisions that are equally satisfactory. Their detailed working out will depend on local conditions. It is all important to visualize these patients as a group and to work out some unified method of caring for them. It is unwise to distribute chronic patients in various sections of a general hospital, even when beds are available, for the general hospital is not planned to meet their needs. They are regarded as interlopers who interfere with the routine of the service. The doctors and nurses are interested chiefly in the dramatic acute diseases and as a rule they do not give chronic patients the special attention and treatment that they need. The atmosphere of a general hospital is not of the best for them as their human and social problems are totally ignored.

It is feasible, however, to set aside one or more wards of a general hospital as a chronic section in which the special technique adapted to these patients can be developed. This has the great economic advantage of utilizing administration, laboratory and similar facilities for both sections of the institution. In many instances such a section can be established to advantage in connection with a municipal or county tuberculosis sanatorium. Here the same saving in overhead is achieved. In addition the grounds and location of such institutions are exceptionally favorable for patients who must remain for many months. Finally, the addition of a general chronic service should be stimulating to the physicians and nurses of a sanatorium, who often have a tendency to stagnate as a result of the uniformity of the clinical material under their care.

The Rôle Played by the Almshouse

Almshouses can rarely be transformed into satisfactory hospitals. Their traditions, their place in the political scheme of things, their reputation as pauper asylums, their geographic isolation, their buildings, which are usually antiquated, and frequently their small size make such a transformation difficult if not impossible. Large almshouses of 400 to 500 beds probably will have to establish their own hospital sections, but it will be an arduous task. The almshouses will have to continue to function as domiciliary institutions for the sick who need only custodial care. But even to carry on this function properly they will have to undergo many radical changes. First, they must arrange a close affiliation with a hospital for chronic diseases which will permit a free transfer back and forth of patients from one institution to the other. Then the almshouses must not be so small that they cannot be satisfactorily conducted except at undue expense. There is no logical reason why every county must have its own almshouse. Not infrequently the community will be better served if two or more counties pool their resources and establish one first-rate institution.

In our solicitude for the welfare of the indigent sick we must not forget the many chronic invalids who are still being supported by their families. Families bearing such a burden for any length

of time soon become destitute and the patient must then depend on public relief. Some provision for patients who can pay a modest sum for institutional care is a necessary part of an adequate program. This applies both to hospital and to custodial care.

The whole problem is complex and touches on many phases of community life. It can be solved only by an intelligent appreciation of the nature and effects of chronic disease and by wise community planning. Many patients can be given assistance that will enable them to remain in their homes. This will involve some form of invalidity or old age pension as well as an extension of the visiting nurse system. For those of the custodial class who are homeless or who offer special problems that render institutional care necessary the reorganized almshouse will be the institutional haven. For those who require much medical attention, and there are many who fall into this category, special institutional provision must be made. In large centers of population hospitals for chronic diseases must be established. In smaller communities special sections for chronic diseases must be provided in existing general or special hospitals. In the administration of these special sections due attention must be paid to the unique medical and social problems presented by these patients.

The achievement of our goal will of necessity be slow and beset with difficulties. It is therefore incumbent upon the various community groups concerned with the problem to lead in the organization and realignment of the resources in their respective communities that may lead to adequate service for the chronic sick.[1]

What New York's Governor Thinks About Compensation Cases

"The handling of compensation cases has been a problem to the hospitals since the passage of the New York Workmen's Compensation Act" writes Franklin D. Roosevelt, governor, New York State, in the *United States Daily*. "First, the handling of workmen's compensation cases involve more specialized services than other classes of cases; second, hospitals generally have not secured payment equivalent to their cost of caring for such cases.

"The type of specialized service which the hospitals are obliged to undertake in workmen's compensation cases can be illustrated as follows: the need for investigation in compensation cases where employment is not acknowledged by the employer; where details of accident are disputed; where employers are not insured; by the need for counsel representing the hospital at compensation bureau hearings and at courts relative to the payment of hospital bills when resisted by employer or the insurance carrier; by the need to send doctors and records as medical evidence at hearings on claims; the need to carry the risk of nonpayment of bills in third party and in uninsured employer cases; the need to advance the cost for medical service for long periods while waiting for the payment of disputed bills.

The Costs of Compensation

"Hospitals are not equipped to carry on such activities. It must, therefore, be borne in mind that compensation work, because of its acute nature and because of this extra administrative work tends to be more expensive than general work although the theory of charging prevailing rates rather than cost plus still applies in this class of cases.

"There is in New York State a great variance among the hospitals as to the amount charged for care of compensation cases. Efforts have been made by a number of hospitals to secure uniformity but only to a small extent due chiefly to the necessity for recognized and agreed standards of work and payment and in calculating costs. The reason for the failure of the hospitals to solve these problems has been that they have lacked forceful coordination sufficient to make it possible for them to solve their problem in a broad way.

"In order to make constructive changes it will be necessary to go into the detailed problem of costs in order to determine adequate rates, payment as related to costs, types of care, definition of terms, elements of unit cost, the question of including taxes, donated services and similar or comparable accounting methods. It is believed that the careful thought and guidance of an important fact finding committee, which in addition to gathering data will act as a leader in bringing together all points of view and coordinating them, may successfully solve this problem.

"Other questions which have arisen and which must be considered by the committee include the wisdom of transferring patients from one hospital to another or from hospitals to the care of other clinics, and the whole question of securing unprejudiced and complete medical testimony in determining the degree and length of disability to assist those charged with adjudicating claims and the question of the advisability of using unregulated institutions for medical treatment.

"It is important that these matters be thoroughly studied on the basis of facts and with a view to determining the public interest and making recommendations how to secure it."

[1]Read at the New York State Conference on Social Work, Elmira.

Where Science and Sympathy Join to Prevent Mental Ills

By J. ALLEN JACKSON, M.D.
Superintendent, Danville State Hospital, Danville, Pa.

THE progress of every movement throughout the ages has been marked by characteristic structures. Churches reflect the progress of religion; school buildings, education; hospitals, humanitarian and medical progress, and modern skyscrapers, big business.

Mental medicine is no exception to the rule. The records from remote periods to the present reveal the fact that, even in this so-called neglected field, the progress of mental medicine is reflected in the structures built for the mentally ill. In Pennsylvania, the effort reflected in the single cell house may be traced through the landmarks of the passing years to its fullest culmination in the Institute for Mental Hygiene of the Pennsylvania Hospital, Philadelphia.

The objectives and purpose of the institute represent the latest thought in (1) an approach to the understanding of human ills and human misfits, (2) an approach to economic distress from the medical angle and (3) research into causes, reactions and their control in individuals classified as suffering from diseased minds. The first two are a decidedly new venture as may be seen from the following outline by Dr. E. D. Bond, superintendent of the institute, in the Danville State Hospital's *Mental Health Bulletin:*

"The need for this new department has long been felt. Of every 218 hospital beds in the United States, 118 are devoted exclusively to the care of the mentally ill, while only 100 are designed for all other patients combined, medical, surgical and maternity. According to the laws of probability 15,000 citizens of Philadelphia who are now well will become patients in mental hospitals within the next twelve months. These

The colonial design of the exterior has been carried out in the interior of the new Institute for Mental Hygiene of the Pennsylvania Hospital, Philadelphia.

compelling data strikingly present the need for progressive measures in the direction of prevention. Another need presents itself in the realm of treatment for minor problems of adjustment. This group consists of a great many persons who may be spoken of as 'normal' but whose personal efficiency could be increased by a little more understanding and guidance. The institute will make it possible for Philadelphia and Pennsylvania citizens for the first time to avail themselves of such treatment in a place primarily set up for this purpose.

"Thus the institute can be of value to the local community and to psychiatry in general by its plans for the prevention and treatment of mental diseases and research into their causes, and by the teaching facilities it will offer to physicians, students, nurses, teachers and social workers.

"It is believed that by research into the causes of maladaptation, the understanding and treatment of individual aberrant mental functioning and by the dissemination of the principles of mental hygiene to the average man and woman there will be considerably less of a loss to the mental and physical economy of both society and the individual.

"The institute will welcome groups of patients who heretofore seldom have come to the attention of hospitals and physicians. One group might come under the general category of marital difficulties—misunderstanding, jealousy and disagreements. Another group to which treatment will be extended is the neurotic or psychoneurotic patients having clinical entities usually designated as neurasthenia, psychasthenia, anxiety states and compulsive and obsessive symptoms. A third group includes individuals somewhat difficult to classify—those who have become incapacitated by useless fears, apprehensions, oversensitiveness, irritability, excessive love attachments and numerous character faults. Some will be taught how to rest and play and work and lead more harmonious and well balanced lives. Training in handling the emotions will be a necessary function.

"In addition, the institute will offer unusual opportunities for children. The Franklin School for problem boys and girls will afford individualized school instruction as well as intensive psychiatric treatment. Some of the behavior problems acceptable both to the Franklin School and the out-patient department for children will be the adolescent difficulties—confused ideals, rebellion, prolonged dependency and vocational guidance. The behavior disorders in children following encephalitis have been and will continue to be treated for rehabilitation. The preschool child will have a place. Classes for parents in child management and in the mental hygiene of childhood will be offered. During the summer months a camp is maintained for children at Ashley, Pa.

"No feebleminded children will be admitted to

Individual fireplaces and furniture resembling that of a private home are features of the private rooms.

The lounging rooms with abundant sunlight and comfortable, cheerful furniture are an adjunct to treatment.

the Franklin School. In no case will either children or adults be committed to the institute. The institute is open only for voluntary patients, be it for a few days' study or for more extended periods of treatment. The institute is not a psychopathic hospital in any sense of the word. The advent of psychopathic hospitals afforded a tremendous stimulus to the investigation of borderline psychotic and definitely psychotic patients and still renders an invaluable service. The institute, however, concerns itself with the average person who might visit the clinic for some annoying psychological symptoms or unhappy problem just as casually as he might drop into a physician's office for treatment of a bothersome sinus infection. The organization of the clinic is such that psychotic cases are not handled in the institute. The out-patient department is carefully organized to provide intensive treatment for each individual patient. A great many patients may continue at home or in business while being seen and treated at the institute."

Dr. Lauren H. Smith, executive medical officer, in announcing the opening of the institute, stresses the purpose and the objectives of the institute when he says: "The services are for both out-patients and for resident patients. There are private accommodations of any type desired for those who remain at the institute for extensive diagnostic service and treatment. Mental factors as well as physical factors will be sought out and treated. Classes in occupational and physical therapy, music and recreation can be used by out-patients or by the patients of any member of a county medical society that wishes to make arrangements for them with the occupational or physical director. Children will be received in the out-patient department and in the Franklin School for problem children. The institute is not licensed and cannot receive any committed patient. It will be greatly interested in toxic mental disturbances and in problems of general convalescence.

"An experiment in medical economics is also planned. It is believed that many patients are now hiding their troubles from physicians because they dread unknown charges on one hand and free clinics on the other. The institute will try to furnish an actual cost-of-care service designed to give persons of moderate means every essential of good treatment including privacy and choice of physician, but with no element of charity. Its experience with such patients it will at once make known to physicians in private practice in the hope that a new group will come to the physicians' offices for help. Private full rate patients will also be received and the institute will be ready to help suitable low rate and free patients."

This background of the objectives and purposes makes possible a better evaluation of this milestone of progress in mental medicine as reflected

in the architectural beauty, design and service departments of the institute.

The institute building itself is a colonial edifice of Indiana limestone. It represents the latest developments in plant and equipment layout for hospitals of this nature. There is a main building consisting of four stories and a basement, with a three-story and basement wing. The interior is of fire resistive construction throughout.

On the ground floor is an active treatment center for patients both in and out of the institute. It has complete equipment for physical therapy, including various kinds of baths, massage, ultraviolet ray, diathermy, faradism and galvanism, and access to the swimming pool and gymnasium. There are examination and treatment rooms for diseases of the ear, nose and throat, and for gynecological, genito-urinary and other afflictions. There is also space for future extensions in the occupational and physical therapy departments.

On the first floor are the main lobby, the private patients' section including physicians' offices, the out-patient department, nursing offices, social service quarters and general surgery, specialty and information rooms. On the second and third floors are rooms for patients, with continuous bath facilities, a sun parlor and spacious lounging rooms. The clerestory or fourth floor is for occupational therapy of all sorts. Provision has been made for sun treatment and there are attractive lounges and an open roof promenade eighty feet long on either side of the building.

Facilities for Special Studies

Doctor Bond states: "The laboratories at the new Institute for Mental Hygiene will afford ample space and facilities for the study of individual patients and for the investigation of group cases. Provision has also been made for neuropathological and experimental studies. In the main laboratory four spacious rooms are assigned to clinical pathology including serology and bacteriology; three to chemistry; three to neuropathology; two to experimental work, and two to photography. A scientific lecture hall is fitted for chemical, bacteriological and pathological lectures and demonstration. The adjoining wing contains a psychological laboratory (three rooms), two or three rooms for individual research workers, a library and stacks and finally a large room, with bath, in which patients may be held overnight for special metabolic or other studies. Other rooms nearby are available for the extension of this idea which, it is hoped, will meet the diagnostic requirements of the physicians in the out-patient clinic without requiring more than temporary hospitalization.

"The staff of the institute consists of psychiatrists, a medical director of laboratories, psychiatric social workers, psychologists, specialists in different medical fields, a school teacher, experienced nurses, occupational teachers and technicians. The capacity of the hospital is 120 beds for adults and twenty-four for children."

The Institute for Mental Hygiene of the Pennsylvania Hospital is a monument to a great advance in the understanding of unfortunate and unhappy individuals, a monument indeed where beckoning arms reach out a helpful salutation to those who are unable to carry life's load and bid them enter the portals of a building dedicated, in the words of Benjamin Franklin, "For the Relief of the Sick and Miserable: May the God of Mercies Bless the Undertaking."

The National Institute of Health and How It Will Serve

The importance of conserving public health was stressed recently in an address to the Senate by Senator J. E. Ransdell, of Louisiana, who is the author of the act creating the National Institute of Health.

He pointed out that many unconquered diseases still afflict human beings. The newly created institute, he explained, will be a "clearing house of health for all mankind."

Much needed leadership in the field of public health research is offered by the health institute, he said. Senator Ransdell urged the members of the Senate to be generous in making appropriations to finance the institute, which, he declared is "the greatest altruistic institution the world has ever known."

The best minds in every branch of science and the Surgeon General of the Public Health Service will be brought together by the National Institute of Health, he asserted. They will meet to ascertain the cause of every disease which afflicts mankind. When the causes become known, he explained, many diseases may be prevented.

The law creating the institute, he said, authorizes the Treasury Department to accept gifts for specific and general purposes and provides that donations of $500,000 or over in aid of research will be acknowledged by establishment, in the institute, of suitable memorials to the donors. "I can not suggest to the philanthropists of America," said Senator Ransdell, "anything that will do as much good to humanity as to contribute generously to the Federal Government for public health purposes in combating disease."

Creating and Supplying the Demand for Better Trained Executives

By OLIVER J. PECORD
Good Samaritan Hospital, Sandusky, Ohio

WHAT are the opportunities for the capable young man or woman in the field of hospital administration?

Walter B. Pitkin in his book, "The Twilight of the American Mind," has several things to say about hospitals and the opportunities for what he terms "the best minds." "Between trustees who do not know the difference between lives and leprosy, on the one hand, and scrub women who think a floor is clean when the inspector cannot see dirt on it, there extends an immense hierarchy of workers who can be well managed only by a truly great executive. But truly great executives are usually employed by immense corporations who pay them what they are worth. And hospitals make it a firm rule never to pay anybody what he is worth lest somebody should pipe up and say that doctors are becoming mercenary."

Dr. Christopher G. Parnall, formerly president of the American Hospital Association, when addressing the members of that body assembled in convention in New Orleans, must have had the same thought in mind, for he said: "In the past we have been too much concerned with the supply of trained hospital executives rather than with the demand for their services." This statement has all the earmarks of a reproach. In order to relieve his hearers of any possible doubt as to his meaning Doctor Parnall further stated: "If trustees more generally recognized the importance of high class executives, the problem of training them would be solved automatically."

Salaries Are Low

The fact that the average hospital trustee does not generally recognize the importance of well trained executives should be an added incentive to those who have the hospital's interest at heart to try to produce more executives of the better type. Certainly the mediocre hospital executive is doing the cause no good; it is highly probable that he is doing positive harm. Without a doubt trustees who attend hospital conventions do not represent institutions with mediocre executives. While the average salary paid to hospital superintendents remains so low, it will be impossible to find for the hospital field competent and trained executives, filled with the missionary spirit, who will accept the responsibility of managing a hospital. There are, however, many worthy men and women who would be willing to accept the responsibility with all its implications, who are now endeavoring to enter hospital executive work but who are at a loss to know how they can equip themselves for such a career.

Training Is a Hit-and-Miss Affair

At the present time no adequate courses in hospital administration are being offered by any of the universities to those who might be interested in entering this field. Up to the present the training for hospital executives has remained a more or less hit-and-miss affair. The nurse must have her training, the physician must have his education; even the dietitian and the technician must receive special training for their work. The executive, however, in too many instances owes his position to circumstances. With the exception of the few men who have been trained by several outstanding hospital executives, the training of those who are eventually to run many of the hospitals of this country remains extremely haphazard. There is room for bigger and better hospital executives, and boards of trustees must be brought to realize the need for and the value of such administrators.

In the meantime little is being done to produce competent administrators. The hospital field has a host of executives whose only function seems to be to act as an animated buffer between the medical staff and the hospital board, so that the board may not get the impression that the staff is trying to run the hospital, or the staff get the idea that the board is endeavoring to dictate to the physicians.

Many suggestions have been made with regard to the training of hospital executives. Some feel that hospitals should be willing to train worthy young men and women; others that there should be university courses for those who desire to enter the executive field.

Since the hospital boards are so urgently in need of missionaries they can scarcely be expected to train personnel at the expense of the hospital. There seems to be but one way at the present time to produce future administrators and that is for the executives who are recognized as leaders in their field to undertake the instruction of the right persons. Naturally not all hospital executives are willing or competent to undertake this work but there are many outstanding men who undoubtedly would be willing to train three or four young men or women in the next five or ten years. It seems reasonable to believe that executives so trained would make competent and influential administrators. In addition such men would be a revelation to many hospital boards who are not accustomed to well trained executives.

The Dearth of Adequate Instruction

To-day the young man or woman who aspires to hospital executive work is tackling an extremely difficult problem. The problem seems more difficult for the young man than for the young woman, for apparently there is a greater demand for women than for men in this field. It is becoming increasingly difficult for those who desire to enter hospital executive work to secure instruction. Unfortunately no definite plan of instruction has yet been devised by those who should be most interested in the problem.

It is evident that the American Hospital Association hopes to solve the problem of training the hospital executive. In its convention at New Orleans the association conducted a round table for trustees. It is doubtful, however, whether educating the trustees to their responsibility can be accomplished without the aid of well trained executives who should be the superintendents of the trustees' hospitals.

Thus it appears that if the hospital trustee is expected to show more understanding of the problems of the hospital, to assume greater responsibility and to demonstrate a more devoted interest, the hospital executive should be the chief factor in bringing this happier condition to pass. Therefore, if the American Hospital Association desires to promote better hospital boards, if its object is to cause hospitals to be more respected by the public, then it is definitely the responsibility of the association, and of its leading members in particular, to undertake the training of competent men and women for executive work. In the end capable executives will create better feelings between the trustees and the hospital and will reflect glory upon the men who train them, upon the institutions they serve and upon the American Hospital Association itself.

The Evolution of the Community Hospital

The way of a community hospital is not an easy one. It has its ups and downs. But in the end the hospital is accepted as an integral and indispensable part of the health activities of the community.

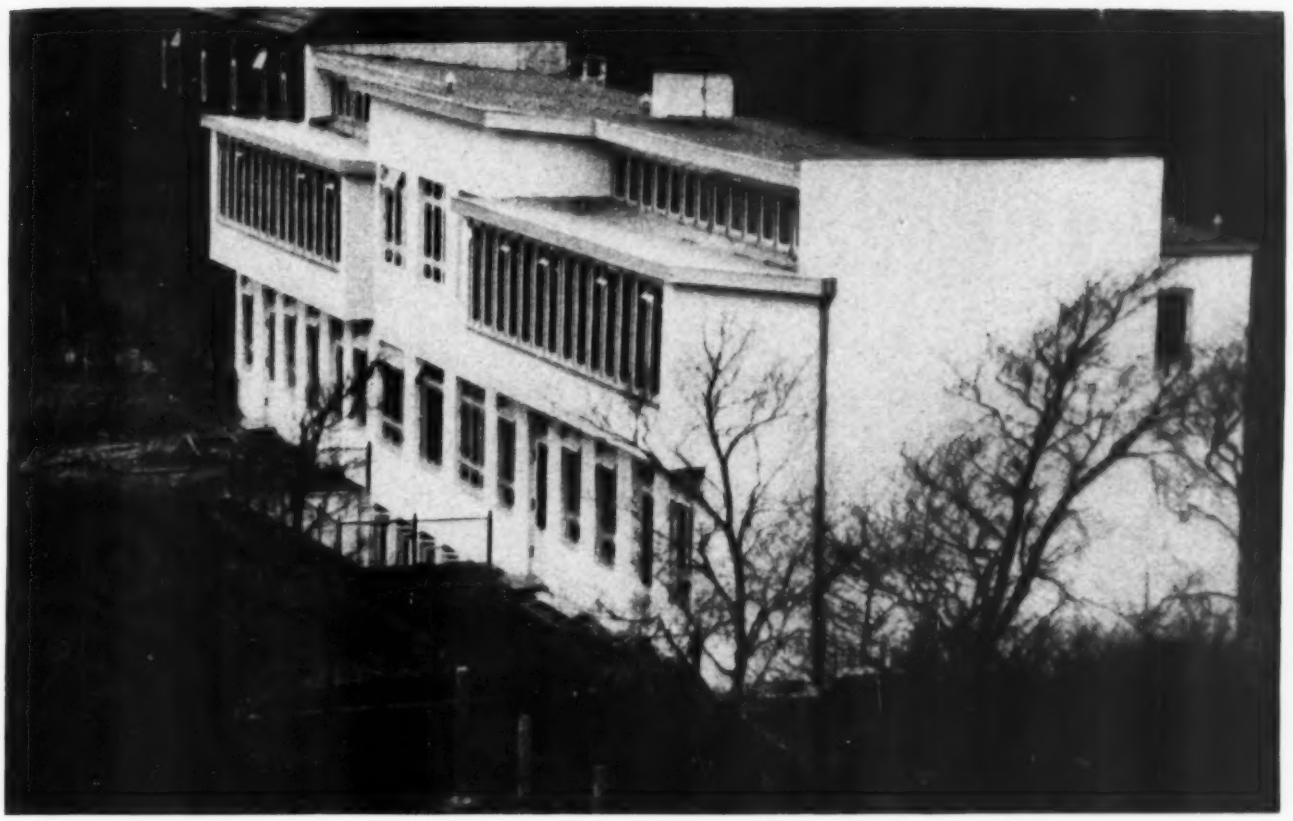
So says the Commonwealth Fund, in whose 1930 annual report is described the development of its six community hospitals in Murfreesboro, Tenn.; Beloit, Kan.; Glasgow, Ky.; Farmville, Va.; Farmington, Me., and Wauseon, Ohio.

"These hospitals have shown somewhat similar tendencies in their initial stages," the report says. "The first reaction on the part of the public is one of pride and satisfaction in the visible evidence of community progress which the new building offers. The financial requirements are taken lightly; the community rests on its oars after raising the money necessary to meet the offer of the Fund and to get the building finished. The riper physicians and a few far-seeing laymen recognize the opportunities for public service which the hospital offers and quitely assume responsibility for realizing them.

"Patients are received; necessary regulations are enforced; bills are presented. Free cases come; operating deficits make their appearance; trustees become nervous; the more conservative physicians hesitate to accept the substitution of free hospital service for private charity work, fearing the loss of some vague lien on a patient's future; strains creep into the relations between staff and superintendent and board. Medical factions jockey for position at the hospital. Meanwhile the care of the patients goes on more or less steadily—well below the capacity of the hospital, in most instances, but gradually increasing.

How a Hospital Benefits a Community

"Gradually the community becomes acquainted with its hospital; there is a friendliness under the surface that can be counted on in emergency; the hospital gathers momentum as a going concern. More of the physicians, exposed to a variety of educational influences through the hospital, catch a glimpse of its possibilities as a center for disinterested medical service and professional progress; the less imaginative begin to feel the tide of public favor which swings toward the hospital, and shape their own course accordingly. Eventually the growing understanding of what the whole enterprise is worth to the community finds expression in a stable financial policy and a generous interest in its development and maximum usefulness."



Calculating Building Costs to Protect the Hospital

A German architect discusses a subject of international import

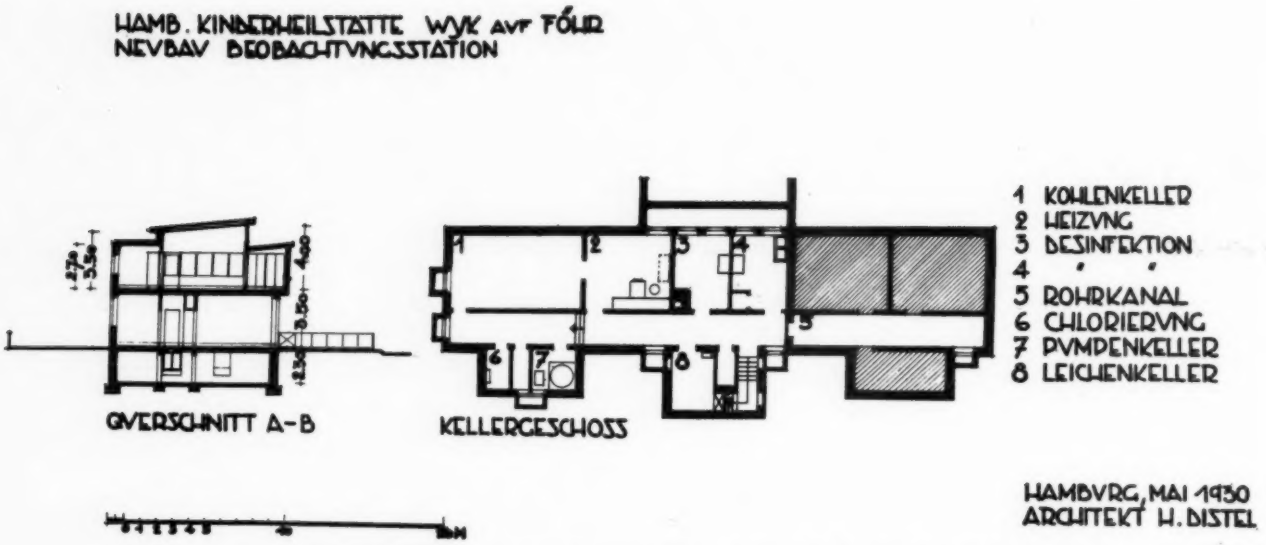
By HERMANN DISTEL
Architect, Hamburg, Germany

THE desire to build inexpensively is felt most strongly by the builder of hospitals. The builders of other public or semipublic buildings may wish for stateliness. But the architect of a hospital is called on to accommodate at a minimum of cost a maximum number of hospital beds. In the "factory of health" the bed is the standard of measurement. The larger the number of beds an architect is able to provide within a certain range of building expenditure, the more highly rank his service and the social usefulness of his work.

To the practical mind the calculation of the cost of hospital construction should not be clouded by mystery. A cold calculation of the amounts of building materials and labor required and the multiplication of these amounts by the prevailing prices are all that is necessary. Similar specifications under similar conditions result in similar prices. Occasional surprises caused by contractors who make bids below the calculated price require the usual caution concerning inferior work.

False Economy

But the burning desire to build cheaply sometimes induces the nontechnical man to believe in miracles. The builder who overlooks the necessity for technical comparison may hope to build far below market value. His faith, like the faith of the sick, is fostered by quacks who offer patent systems, new discoveries, standard plans, in short those patent medicines which the physician, in his own field, knows only too well. Relentless advertising, heedless generalization, confusion of exceptional with normal conditions, unsatisfactory work, harm to the reputation of the conscientious



Plan of the basement floor of the contagious pavilion of the Children's Hospital, Hamburg.

architect and damage to architecture in general are the incidental features that go with this neglect of common sense. But sometimes the miracle of low-priced construction actually happens. If a contractor finds himself in financial extremity he smashes prices. Sometimes he survives until the building is finished. But woe to the hospital director who has to manage a building constructed by such a contractor.

The Cost of Construction

The cost of hospital construction basically depends on the following six factors: (1) the building program of the medical or other authorities who are planning to build, (2) the capacity of the architect to realize this program, (3) certain local conditions, (4) the type of construction, (5) the quantity and quality of the equipment and (6) the general condition of the building industry.

Right from the beginning the building program should harmonize the requirements and the available means. But it is essential that the cooperation between the managing physician or director and the architect should begin at the right time. The architect specializing on hospital construction can sound his warning before it is too late, thereby reducing overhigh expectations.

The local conditions are in most cases unalterable. These cover such items as making the building site accessible by paved streets, the provision of water, sewerage and electrical service, the size and shape of the building site, and the financial conditions. But even in dealing with these conditions it is worth while to hear the views of the architect.

In realizing the building program in the physical terms of mass and space, the margin of waste is, for an experienced architect, smaller than a physician is apt to think. The local building by-laws compel the architect to follow certain lines of construction. Research work of the FANOK (*Deutscher Fachnormenausschuss*), an organization whose object it is to standardize building materials throughout Germany, and the excellent studies of such leaders as Winterstein, Lang, Gottstein, Dosquet, Gruber and Altherr have produced many results. Many practical values in limiting the margin of waste have ensued from this international movement. Such errors as the construction of oversized halls and staircases, too wide corridors, exaggerations in the heights of rooms and complicated roofs will not be repeated by the experienced architect.

It is true that the managers of large hospitals sometimes complain that the same mistakes and the same causes of additional expense continue to present themselves. The explanation of this fact may well be that too many architects or building officials, when the task of building a hospital presents itself to them for the first, last and only time, still flatter themselves that some more or less extensive trips of inspection and study will enable them to achieve success. A physician who is not a surgeon would not think of performing a surgical operation.

What Winterstein wrote in the *Deutsche Bauzeitung* is correct: "A good hospital can be built only by an architect who has sufficiently grasped the medical mentality and has learned to appreciate the technical solutions required by the physician." Vice versa the doctor or managing hospital director who has acquired something of a technical mind will build the most economical hospital.

To-day the type of construction is to a considerable degree determined by building by-laws

and by technical and hygienic requirements. To make a hospital soundproof is expensive. The cost of hospital construction is but little influenced by the material chosen for the façade. The question of where to place the wiring and service pipes is generally overestimated. The contractor serves his own interest in avoiding expensive detours. In erecting a modern hospital there is always a temptation to economize in construction cost by inferior workmanship. In such cases the inevitable result is that greater cost of upkeep soon wipes out any savings that may have been made in capital cost.

In selecting the quality of the equipment one may intentionally or unintentionally ask for de luxe furnishings which, of course, are expensive. Such an intention is justified if the luxurious equipments allure patients who are able to pay for them. But they are never justified if they result from a thoughtless liberality on the part of the building authorities or from the ambition of the architect. In the wise use of luxurious equipment America may serve as a model. The general equipment of American hospitals is extremely simple. Only certain groups of rooms such as lobbies and private rooms are elaborately equipped. And this equipment generally stands justified by psychological and economical reasons.

Such equipment as the tiling of walls to obtain a reduction in the cost of upkeep should not be figured as equipment de luxe.

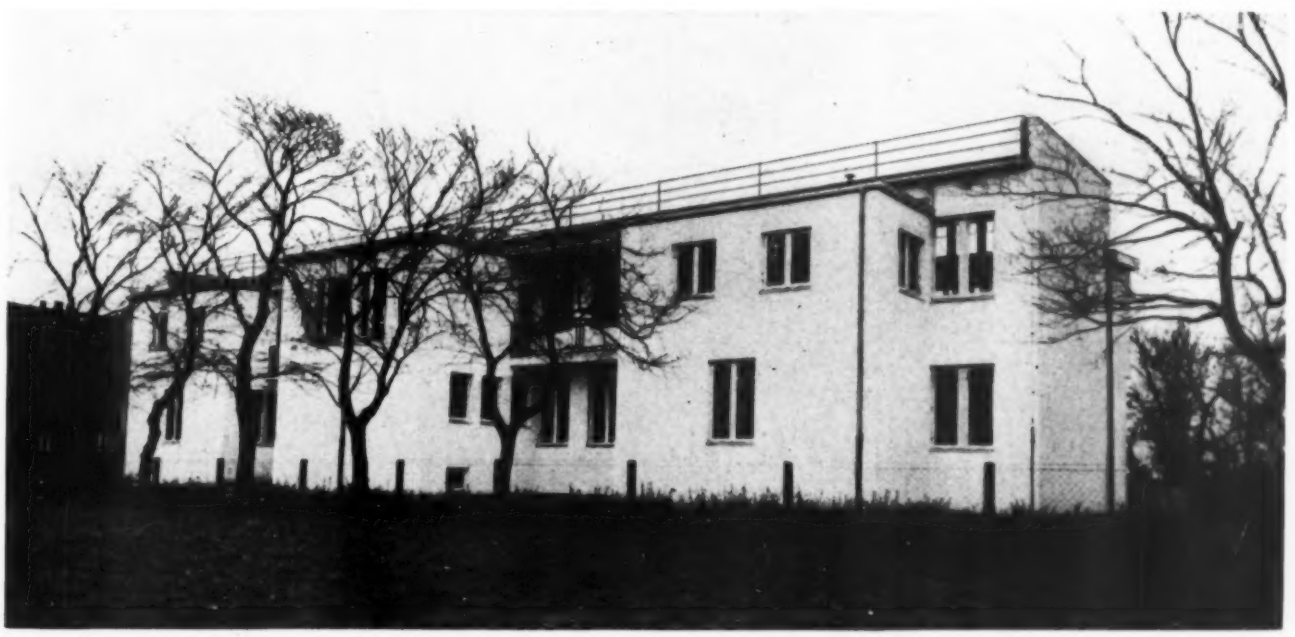
The condition of the building market is the strongest influence in raising or lowering the price of a hospital. Nothing could have proved this better than the enormous fluctuations in prices of building construction before and after the war, and, in Germany, during the period of "inflation." But even under normal conditions equally large price differences prevail at the same period in different localities. For this reason it is practically impossible to compare the building costs of hospitals constructed in different cities. Three factors determine the price—building materials, wages and general expenses (overhead expenses and profit). Building materials and wages absorb about equal shares of the price.

All three factors are subject to considerable variations from town to town and from country to country. Building materials become cheaper or dearer according to local conditions, such as supply and demand, means of transport and the type of approach to the building site. Wages to-day are generally determined by trade union agreements. If piece work is taken into account, the wages in Hamburg are about twice as high as those paid in Silesia-Posen. General expenses are higher in large cities with their different standards of living than in rural districts.

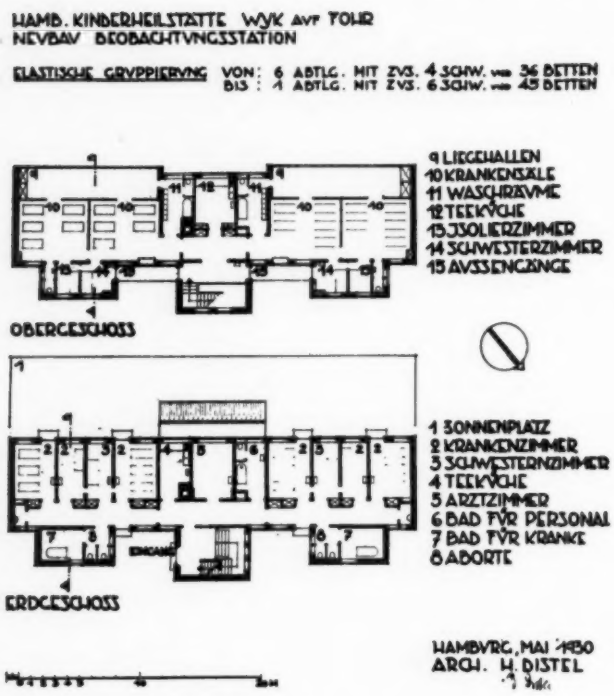
It is evident, therefore, that the price of building is affected by numerous factors that cannot be influenced by the architects or by the building authority.

How Prices Are Measured

The prices of hospital construction to-day are measured either in relation to the price per cubic foot or the price per hospital bed. The price per cubit foot includes the cost of excavation, construction and complete fixed equipment. In estimating the price of a proposed hospital both standards of measurement can be used with advantage only by the experienced hospital construc-



The new pavilion for the Children's Hospitals of the City of Hamburg on Wyk, Isle of Foehr.



Plans showing the first floor, below, and the second floor, above.

tor. For the price per cubic foot definite rules of calculation are lacking. The larger or smaller number of cubic feet that a builder may assume as existing in a hospital planned by or for him depends upon his conscientiousness as a calculator. He can divide the estimated price of the whole building by the number of cubic feet he assumes as existing therein and may thus arrive at a higher or lower price per cubic foot to suit his fancy.

Cost Calculations Are Often Misleading

Most calculations of cost per hospital bed are impractical and misleading. Dr. S. S. Goldwater, consultant, New York City, has clearly pointed this out in his paper to the first International Hospital Congress. Prices per cubic foot or per bed are often used irresponsibly to compare the cost of the simple hospital, without special equipment, with establishments including operating rooms, x-ray departments and private baths. The same error is made in comparing the cost of hospitals with and without dormitories for nurses and with and without ward kitchens and laundry equipment. The price for one hospital may include heavy expenses arising from opening the building site by streets and service pipes. Another hospital may be built upon a site already provided with these essential features. Sometimes fittings for sterilizing, etc., are reckoned as a part of the construction. Sometimes they are considered to be parts of the hospital inventory.

When a hospital is built by an official architect to a public authority, his salary as a rule is not reckoned in as part of the building cost, although before the war the report of the technical officials in the service of German states and cities stated that building plans made by officials cost no less to produce than those made by private architects. All these incongruities and incommensurabilities are further complicated by the differences of wages and prices of materials in different periods and localities. The net result is that the cost of building is different for each hospital.

Why Standardization Is Needed

Correct comparisons could be made only if the methods of comparisons were standardized in each country or, better, internationally standardized. It is essential that one should know not only the name of the unit of measurement, but also what is covered thereby. It is only when one compares absolutely similar types of construction that such conceptions as the price per cubic foot or per hospital bed can be wisely used. If the basis of comparison is present, there is a real possibility of critical examination, of checking errors in planning and of finding, with a measure of accuracy, where too much has been charged.

Only pure masses of construction can be usefully compared. Any preparatory work, and such items as the raising of funds, street construction and the cost of the site, must be excluded from the figures of comparison.

A start has been made by the FANOK in the systematization of the calculation of cubic feet. First of all the limits of calculation have to be determined. Factors such as expensive foundation work, the construction of light wells, the types of basements, of roofs, whether sloping or flat, of balconies, verandas, roof gardens and many others can be covered by the price per cubic foot only after a careful determination of the percentage to be allowed for the individual items.

In calculating the building cost by the price per bed it must first be determined whether or not the beds of physicians, attendants and nurses are to figure in the total. Beds for children will of course come in with a lower percentage. It is of special importance to determine the full capacity of a hospital ward. Even if the ward is more luxuriously furnished or for other reasons contains fewer beds than normal, this full capacity should figure in the total.

More interesting still to the technical adviser are the number of cubic feet of construction and the number of square feet of floor space per hospital bed. But even when all these items are reckoned, a satisfactory means of comparing different hospitals is not yet provided. Such comparisons are possible only if the hospitals to be compared

COMPARATIVE SIZES OF VARIOUS DEPARTMENTS

		Number of Cubic Meters	*Percentage*
Group No. 1	Wards	8,238.89	42.53
Group No. 2	Administration	746.27	3.85
Group No. 3	Staircases, elevators	2,271.93	11.72
Group No. 4	Distribution of laundry storage for clothes and trunks	901.88	4.66
Group No. 5	Machinery, heating, workshop, disinfection, laundry	1,236.40	6.38
Group No. 6	Kitchen department	400.05	2.27
Group No. 7	Operating rooms	1,387.99	7.16
Group No. 8	X-ray and ultraviolet ray departments	784.47	4.04
Group No. 9	Clinics	199.06	1.03
Group No. 10	Service department	2,085.33	10.76
Group No. 11	Private apartments	321.02	1.66
Group No. 12	Reading and research rooms	765.20	3.94
	Total of cubic meters	19,378.49	100.00

are analyzed according to the individual qualities of their cubical content and floor space. As in arithmetic, useful additions can be made only if the units are similar. Only sums of similar units can be compared.

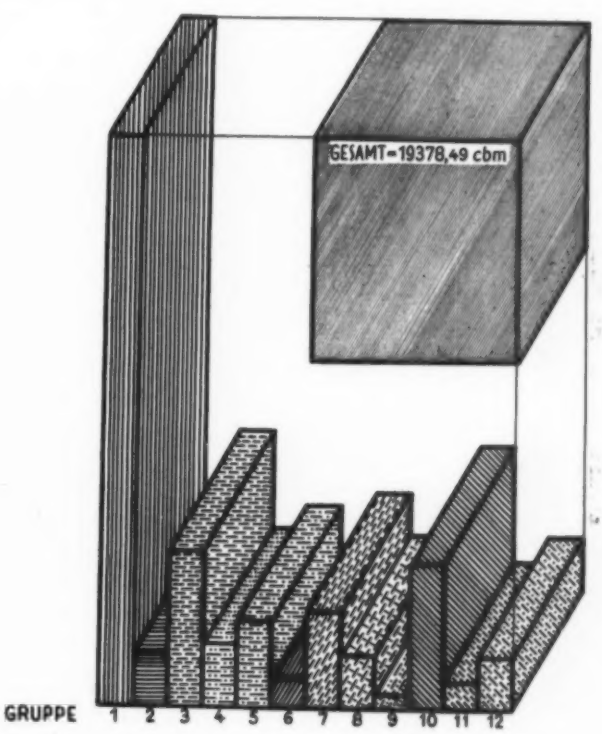
As a point of departure in making useful comparisons, a hospital of the simplest description and assumed to be constructed under actually prevailing conditions should be taken. Hospitals constructed before the war do not provide useful data in making comparisons for practical purposes today. This simple hospital selected as a basis of comparison should be regarded as consisting exclusively of wards for the sick and as provided only with the absolutely necessary entrances, staircases and all that is required to make up the nursing unit.

This conception of the simple hospital may be regarded as a basic cell. This basic cell is conceivable either as a part of a large hospital or as an independent structure in the open country. In calculating the cost of a more elaborate hospital, the basic cell and each additional department, such as rooms for operating and for x-ray service and bathrooms, have to be clearly analyzed according to their cubical mass of construction and floor space. The additional departments thus analyzed must be valued upon a percentage basis and each cubic foot or each bed of the basic cell must carry its share of the additional expense. By adding or omitting the respective percentage, one will be able to make comparisons which will avoid most sources of errors that falsify calculations even though these comparisons cannot be mathematically correct.

If, for instance, a hospital has a nurses' dormitory large enough to serve 30 per cent of the building, the remaining 70 per cent can be compared with a hospital without dormitories. The technical possibility of measuring the amount of cubic feet per bed is evident.

How the different types of rooms may compare in size is graphically illustrated by the accompanying chart and explained by the table.

Less easy is the comparison of cost per bed. This comparison is complicated if the hospitals to be compared have been constructed at different times or in different localities, that is, at prices that are not commensurable. For example, the wages in Hamburg are twice as high as in the rural districts of Silesia; if it is assumed that the wages actually make up 50 per cent of the cost of construction, the building expenditure in Ham-



Graphic comparison of sizes of different rooms.

burg may easily amount to 150 per cent of that in Silesia and must still be called equal. The same is true in regard to the cost of materials. It may even happen that a building authority actually erecting hospitals in two cities may pay twice as much in one city as in the other and still get full value for the expenditure in both cases. These differences may be even larger than 100 per cent if different countries are compared. In other words, comparisons of absolute price quotations are generally worthless.

In calculating building expenses one may nevertheless stand on solid ground, provided the method of the economist in using an "index" is copied. The items that enter into the making of such an index for the use of the builder are: the price per cubic foot of the basic cell of construction, the average figures of wages and the prices of building materials. All these items should appear in the index according to their due proportion. The index must, of course, be built on a basis of postwar prices. To calculate with prewar prices that have no meaning any more is an abuse that must be abandoned. It is safer to rely on the rule of thumb methods of the clever mason than to use prewar figures for calculation.

If at a definite date there should be established in the different countries and cities (1) the price per cubic foot of the basic cell, (2) the most important wages and (3) the prices of building materials, these would together stand established as elements of an average index figure. The height of this index figure would determine what prices per cubic foot or per hospital bed should be regarded as possessing equal purchasing power.

The goal of all investigations of this kind is the protection of the hospital authorities against overcharge in building cost. Experience has shown that careful control can influence prices and ward off harmful manipulation of these prices by trusts. Beyond this there exists a possibility of taking advantage of the building market by a wise selection of the time of construction. A hospital built during a period when the building market is depressed will be much less expensive than a structure erected while the building market is booming.

The markets of the world at present are passing through a critical stage. This crisis, according to leading economists, will last until 1935. If this calculation is reliable, the coming five or six years should cover a period especially suited to hospital construction. Hospitals constructed during this period will be considerably cheaper than similar hospitals built during the past five years. Serious crises of unemployment are now menacing the political economy of most countries. And the construction of hospitals during a period of depression will render a great public service by providing useful work for the important industry of building.

Simplicity of design and construction materials marks the exterior of the new pavilion at Hamburg.

Delightful Stay Abroad Is Promised Delegates to Vienna

THE impulse toward the solution of problems relating to hospital building, administration and care that was generated at the first international congress in Atlantic City, June, 1929, is expected to be given greater momentum at the second congress to be held in Vienna, June 8 to 14.

The thirty-six nations that were represented at the first congress are expected to be greatly augmented, because of Vienna's easy accessibility to a large number of European countries. The success of the second congress, according to those in charge of the plans and program, will duplicate if not exceed that of the first.

The official opening of the congress will take place on Monday, June 8, in the ceremonial hall of the *Neue Hofburg*. Reports and questions to be considered at the congress, together with those in charge of the various discussions, are as follows: hospital building costs, Hermann Distel, Hamburg; nursing, Christiane Reimann, secretary, International Council of Nurses, Geneva; hospital terms and definitions, Dr. J. Wirth, Frankfurt; auxiliary hospital activities, Dr. J. L. C. Wortman, Hilversum; hospital legislation, W. H. Harper, house governor and secretary, Wolverhampton and Staffordshire Hospital, Wolverhampton, England; dispensaries, Dr. E. H. L. Corwin, New York City; nutrition, Professor von Noorden, Vienna; effect of health insurance on hospital practice, Dr. T. B. Layton, London; the place of neurology and psychiatry in the general hospital, Dr. W. Alter, Düsseldorf.

An international hospital exhibition, set up by the organizing committee and including not only scientific but industrial exhibits, will be held during the congress.

The scientific exhibit will deal with all phases of hospital work—laboratory, clinical, statistical, economical and social. There will be in connection with it a valuable exhibition of plans and models of

Vienna still retains the romantic atmosphere of the old days of the monarchy. The upper picture shows a military review before the court castle, the former city residence of the country's rulers. The lower picture is a scene near Zell am See, one of the many beautiful mountain resorts within motoring distance of the Austrian capital.

modern hospitals. This part of the exhibit will be of interest not only to hospital administrators but to architects and the general public as well.

The commercial exhibit will include the vast range of articles required by hospitals. It will include medical and surgical apparatus, pharmaceutical supplies as well as food products and general hospital equipment and appliances. The exhibit will be open to all foreign exhibitors. Arrangements will be made with European customs authorities to allow free transit and free entry, under bond, of all goods originating in foreign countries intended for either the technical or educational exhibits.

While the congress is in progress, arrangements will be made for the delegates to visit the Austrian state and municipal social institutions and, later, the hospitals in Budapest. Prior to the opening date of the congress, the American Express Company will arrange a schedule of visits to British, Danish and German hospitals. The date of this precongress tour is May 14 to June 6.

Postcongress tours will begin on June 14 and 15, and American delegates will have the choice of four routes by which to return home. These schedules have been carefully planned and offer the delegates a splendid opportunity to see Europe.

Sightseeing in Vienna

Arrangements have been made for sightseeing in Vienna and excursions into the environs. These trips will include: a sightseeing drive by autocar, including a visit to Schönbrunn Castle; a drive through New Vienna; an excursion to Klosterneuburg where the abbey will be visited, and a drive to Cobenzl where tea will be served; an excursion to Kreuzenstein Castle and one through the Vienna Forest, by way of Modling, Heiligenkreuz to Baden; an all day excursion to the Semmering and Rax; visits to museums and famous galleries; a visit to the Spanish Riding Academy and a tour to Budapest. The delegates will also be entertained at a performance of the famous Vienna opera.

Vienna is a cosmopolitan city, a world center of music, art and medicine. It is hospitable, friendly, charming.

It stands on the right bank of the Danube and on the Donaukanal, a narrow arm of the river, into which fall several small streams. It stands in a plain with the conspicuous Wiener Wald Mountain boundaries at ten or twelve miles distance on all sides. Most of the city rises from the right bank of the Donaukanal, on a considerable acclivity. Vienna is a handsome well built city, with fine squares and straight and spacious streets, well kept.

Vienna is a city that abounds in culture in the truest sense of the word. Her universities, her art academies, her museums, her music conservatories all attest to this. Vienna is a humanitarian city, her hospitals, her clinics and her many charitable institutions are proof of this. Vienna is a practical city, her manufactures are numerous and include cotton and silk goods, leather, porcelain, musical instruments, hardware and many other articles. Vienna is a gay, light-hearted city, with her gardens, her cafes, her theaters and her other famous places of amusement.

Vienna has a population of 1,843,759, which is approximately 30 per cent of the whole population of the republic.

A Viennese Physician Speaks on the Subject of Social Legislation

That social legislation has failed to deal with the rights and duties of the hospital is the opinion of Dr. J. Tandler, commissioner of health, hospitals and public welfare, Vienna. And this in spite of the fact that hospitals represent a capital force in the fight against disease. According to Doctor Tandler in an article in *Nosokomeion,* workshops for repairing motor cars are better organized from the point of view of labor regulations than those intended for suffering human beings.

"Physicians have practically no part in modern legislation and organization," says Doctor Tandler. "Bound to the treadmill of their daily rounds, they have hastened from one patient to the other anxious to relieve and cure each particular case, failing to recognize the potency of the mass to shape the destinies of mankind. They feel no call to tread the devious paths of social legislation, nor to grasp the complex machinery of hospital management."

Doctor Tandler drew up in 1919 and 1920 the Austrian Hospital Act, which was passed by Parliament on July 15, 1920. This experience gives authority to his opinion on what such an act should accomplish:

"Responsibilities and duties must be clearly fixed in all matters pertaining to the foundation of public hospitals and institutions for the care of the sick. Regulations for the daily management of such establishments must be laid down in the smallest detail. The how and wherefore in the discharge of patients, the relationship between the outpatient department and the hospital, the method of keeping the records of patients, the condition on which such records must be available for study and for whom, must all be defined. The mutual relationship between the teaching and ministering duties of the hospital should also be settled, including the question of the supervising authority."

Practical Administrative Problems:

Increasing the Income by Means of Special Services

By JOSEPH C. DOANE, M.D.
Medical Director, Jewish Hospital, Philadelphia

IT HAS often been truthfully said that the members of the medical staff are the salesmen of the service that the hospital offers to the public. Notwithstanding the fact that because of their confidence in the hospital, representatives of the public in varying numbers choose to patronize a particular institution, yet in the great majority of cases the physician is the determining factor in directing patronage to the hospital. Because this is true, the ill effects of the practice of allowing one physician to hold numerous staff positions should be apparent to all. In some institutions it is definitely stated in the staff regulations that no physician may hold more than two positions and furthermore that the services covered thereby may not be carried on concurrently.

In an Eastern hospital, the board of trustees is now facing the problem of discovering the best method to adopt when specialty staff physicians persist in referring their private patients to a teaching hospital, the staff members of which hold professorial positions in the medical school conducting this institution. This hospital is but one of many which have been accustomed to point with pride to the fact that outstanding physicians appear on their staff roster, yet they are obtaining little if any practical service from the holders of these positions. Perhaps an effective method to adopt in reorganizing such a staff would be to bring about a complete change in the system of staff nomenclature by creating an emeritus and consulting staff. Once this is done, the next step is the elevation of nonactive staff members to places in these groups and the election of more active and more loyal physicians to fill the vacancies thus created. Such a plan would be less likely to create ill feeling among the physicians affected than one contemplating an abrupt severance of their connection with the hospital. The active staff of an institution should consist of young men at the high tide of their professional activity or even those with a considerable portion of their medical future ahead of them. Staffs that are not from time to time so reorganized are likely to develop a state of stagnation that can be likened to the dry decay that undermines the life of a tree.

Again, for the sake of emphasis, it may be stated that the number of private patients that a physician refers to the hospital must not be the only consideration. But the corollary to this statement is equally true—that the more efficient and distinguished a physician, the greater the number of private patients that will find their way to the institution he serves. Even generalizations on this subject are dangerous, because often the play-actor, the sensationalist, the physician of shallow intellect and strong personality, may for a time fill many private rooms. Such popularity, however, is most likely to be transient.

What the Staff Member Owes the Hospital

Many believe it fair and businesslike for a board of trustees to ask the following question and to require an affirmative answer to it: "If you are elected a member of this staff, will you send your private and ward patients to our institution?" Such frankness while both businesslike and necessary frequently has its real or implied dangers. No board of trustees should put itself in the position of appearing to sell a place on a hospital staff. And yet it has been frequently remarked in this magazine that staff appointments carry with them not only an honor to the recipient but also a definite obligation on his part to the hospital. The pledge of loyalty of an applicant for a hospital staff appointment not only should cover the question of patronage from the standpoint of the private patient, but also should refer to the use of many other services that the hospital has to sell.

The bill of the private patient includes many items other than those that cover the expense of his board and room. Frequently extra charges, such as those for x-ray studies, laboratory work,

physiotherapy and unusual drugs, may amount to from 40 to 60 per cent or even more of the whole cost of hospitalization. Rarely does any difficulty arise as to the lack of a willingness in physicians to utilize these hospital services in the study of in-patients. In some instances no such problem arises because many hospitals have adopted a flat fee policy which includes the board of the patient as well as certain of the extra charges most commonly necessary in his study and treatment. Rarely, however, is there included a flat charge for x-ray studies, since the amount and expense of this type of service are so variable. It appears to be a fair arrangement for the hospital to decrease the expense to semiprivate and pay ward cases for this type of service, as compared with the scale of charges in effect for private patients. Patients admitted for operation, or for treatment for a medical ailment, therefore, will usually patronize the hospital's special treatment and diagnostic facilities.

In two other types of cases there is less likelihood of a routine use of the facilities of the hospital's specialty department. Reference is here made to the short study case and to patients referred to the hospital from the office practice of physicians, for various types of investigative or therapeutic service. Indeed in the short study case, there appears to exist a real demand for some practical recognition on the part of the hospital of the need for provisions for performing this type of work. In some institutions, an effort has been made to supply a service that covers all types of specialty study as well as the assistance of one or more special consultants, when their opinion is desired. Below has been set down the list of rates compiled by an Eastern hospital covering this so-called health inventorium or diagnostic work.

Focal Infections $306.00

Hospital room—4 days.
Internist, surgeon (urologist), otolaryngologist, dentist, coordinator.
X-ray—Teeth, head, cholecystogram, genitourinary study.
Laboratory—Local cultures, blood urea nitrogen, blood sugar, blood Wassermann, blood culture, complete blood count, urinalysis and phenolsulphonphthalein test.

Infections—Soft Tissues $144.00

Hospital room—2 days.
Internist, surgeon, otolaryngologist, coordinator.
Laboratory—Local cultures, blood urea nitrogen, blood sugar, blood Wassermann, blood culture, complete blood count, urinalysis and phenolsulphonphthalein test.

Neurologic Study—Nervous Diseases.... $261.00
(With Mental Examination)..... 286.00

Hospital room—4 days.
Internist, surgeon, neurologist, oculist, otolaryngologist, coordinator.
X-ray of head and spine.
Laboratory—Spinal fluid, complete, including Wassermann and colloidal gold, blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Tumors of Body Surface..... $139.00

Hospital room—2 days.
Surgeon, internist, coordinator.
X-ray—Extensive examinations of lungs, long bones, etc.
Laboratory—Blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis, phenolsulphonphthalein test and tissue examination.

Diseases of Bones and Joints..... $207.50

Hospital room—3 days.
Internist, surgeon, orthopedist, otolaryngologist, coordinator.
X-ray—Extensive examination including teeth.
Laboratory—Numerous cultures, blood culture, blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Traumatic Lesions of Head and Extremities $192.00

Hospital room—3 days.
Internist, surgeon, orthopedist, neurologist, oculist, otolaryngologist, coordinator.
X-ray—Extensive examination.
Laboratory—Blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, and phenolsulphonphthalein test.

Endocrine Deficiency..... $197.00

Hospital room—3 days.
Internist, surgeon, neurologist, coordinator.
X-ray of head.
Laboratory—Basal metabolism, blood urea nitrogen, blood calcium, blood phosphorus, sugar tolerance test, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Asthma $190.50

Hospital room—3 days.
Operating room.
Allergist, bronchoscopic examination, otolaryngologist, coordinator.
X-ray—Radiograms of chest.
Laboratory—Protein skin reactions, sputum routine, sputum culture, blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Lesions of Ear, Nose, Throat, Sinuses, etc.. $149.00

Hospital room—2 days.
Internist, otolaryngologist, coordinator.
X-ray—Head.
Laboratory—Cultures: tonsils and sinuses,

blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Gallbladder Disease $237.50

Hospital room—3 days.
Internist, surgeon, coordinator.
X-ray—Genito-urinary study.
Laboratory—Blood sugar, blood urea nitrogen, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.
Cholecystogram.
Fractional gastric analysis.
Van den Bergh's test.

Lesions of Rectum $192.50

Hospital room—3 days.
Operating room.
Internist, surgeon, coordinator.
X-ray—Genito-urinary study, barium enema.
Laboratory—Blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

Lesions of Kidney, Ureter and Bladder ... $181.00

Hospital room—4 days.
Operating room.
Internist, surgeon, urologist, coordinator.
X-ray—Pyelogram.
Laboratory—Blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis and phenolsulphonphthalein test.

General Health Study $140.00

Hospital room—2 days.
Internist, otolaryngologist, oculist, coordinator and any other specialists needed.
X-ray—Teeth.
Laboratory—Blood urea nitrogen, blood sugar, blood Wassermann, complete blood count, urinalysis, phenolsulphonphthalein kidney function test and basal metabolism.
Electrocardiogram if indicated.

When confronted by the foregoing prices, the average middle class patient must stand aghast to observe how much it will cost to have a study made to discover the presence or absence of focal infection or to have disease of the gallbladder or lungs diagnosed and treated. Such a scale of prices is not likely to result in the greatest possible service to persons most in need of this study. It seems questionable whether it would not be cheaper for the average patient to be hospitalized for a slightly longer period while undergoing a thorough physical examination performed under the direction of a single competent physician. Moreover it is questionable whether the services of two or more consultants at a basic rate of $25 each are required in the average case. While it would perhaps be more difficult for a patient to visit the offices of several specialists than to cause these physicians to visit and examine him in a comfortable private room in a hospital, it is probable that the financial saving to the patient thus brought about would more than compensate him for the time and effort thus expended.

The foregoing plan is certainly idealistic and no doubt is efficient. Its unsoundness lies in the excessive expense to the middle class patient. There can be little doubt that such a service could be of material aid to those of more fortunate status who desire a medical check-up. Nevertheless all hospitals should recognize that a distinct need exists for this type of diagnostic service. For the middle class patient, perhaps the diagnostic clinic may serve a useful end. If the income of the hospital is to be materially increased by the organization of a diagnostic in-patient service, the total expense to the patient must be scaled to the minimum. Moreover little need exists for fixing a flat rate for the wealthy.

In other institutions, instead of the adoption of a flat rate card covering all types of diagnostic and therapeutic service, special flat rates have been established for services rendered by the institution's several specialty departments. For example, in offering to community physicians attractive rates for the laboratory study of their patients, a Southern hospital has drawn up the following price card:

Diagnostic Study Cases

With the view of making it possible for members of the staff to send diagnostic study cases to this hospital, the following charges have been made effective:

Rate of the room—$10 per day.

Laboratory fees as follows: blood sugar, blood urea nitrogen, fractional gastric analysis, urinalysis, complete blood count, Wassermann and feces for a flat rate of $20.

If only a blood study is required consisting of blood sugar, blood urea nitrogen, complete blood count and Wassermann the flat rate will be $15 in addition to the room charge.

Laboratory Fees for Patients Not in the Hospital

Blood sugar	$ 3.00
Blood urea nitrogen	5.00
Blood uric acid	5.00
Blood creatinine	5.00
Blood CO	3.00
Blood Van den Bergh	5.00
Blood calcium	5.00
Blood phosphorus	5.00
Sugar tolerance	15.00
Fractional gastric analysis	10.00
Blood cholesterol	5.00
Blood chlorides	5.00
Guinea-pig inoculations	5.00
Tissues	5.00
Urine	1.00
Complete blood count	5.00

White and differential count	3.00
Wassermann	5.00
Spinal fluid	5.00
Colloidal gold curve	3.00
Sputum	1.00
Feces	1.00
Smears	1.00
Cultures	1.00
S. C. A. agglutination	5.00
Widal (complete)	1.00
Basal metabolism	10.00

Perhaps the most common request from physicians is for the quantitative chemical determination of various organic and inorganic ingredients of the blood. The estimation of the amount of blood sugar and blood urea nitrogen is perhaps the most common of these requirements. A request for blood counts perhaps ranks next in frequency. If an institution can furnish an attractive flat rate covering blood chemical determinations and blood counts, it should be able to build up a lucrative service along these lines.

In another hospital, a similar flat rate for the performance of various laboratory studies has been set. Under this plan the patient is required to spend at least twenty-four hours in the hospital, for which he pays the regular room rate in addition to his laboratory fee.

A few months ago a national surgical association wisely suggested the idea of increasing the number of periodic health examinations by urging all hospitals to offer room and specialty department facilities to community physicians for the short time study of their patients. This health inventorium scheme has many possibilities. In addition to the physical arrangement for the reception of such patients, there may also be added the cooperation of a consultant service if desired, regular staff members serving in this capacity at a minimum of expense to the patient. In this type of case, nose and throat, eye, chest, cystoscopic or other special examinations could be available for the expenditure of such a modest fee as perhaps ten dollars an examination.

In the further development of the scheme for providing facilities for periodic health examinations and for other short time studies, the hospital should endeavor to set aside one or more rooms at a slightly reduced rate to which nonstaff members may feel free to send their patients. The methods of admission of patients to these rooms and the means by which specialty studies may be promptly secured should all be matters of administrative consideration in order that unnecessary time and expense may be spared the patient. None will be able successfully to contradict the statement that the average office periodic health examination is far from complete. Moreover, while physicians everywhere are wisely preaching the doctrine of the advisability of the early discovery and the prompt correction of physical defects so as to spare the patient future serious disease, too little attention has been given to either the technique or the scope of such studies. Certainly, the physician in general practice is far too hurried and often not sufficiently public health minded to render to the patient seeking such aid as effective a service as could be secured during a brief hospital stay. It is the hospital's obligation not only to provide facilities for such studies but also to popularize the need for the practice of good preventive medicine.

The Hospital Meets Competition

So far we have considered only the high points of the financial and social possibilities inherent in the rendition of the effective short time diagnostic service which should be supplied by the hospital. There is a third class of patients, whose physicians desire but one or more of the types of specific information that may be furnished by the hospital clinical laboratory. In most institutions, the amount of money that accrues from the performance of tests for patients not residents in the hospital is small. There have sprung up in many places, particularly in urban communities, commercial laboratories, which appear to prosper financially. The hospital has found itself unable to compete successfully with these laboratories, and there are several good reasons why this is the case.

In the first place, the hospital has too long remained aloof from the practice of competing for patronage. It is true that it has usually been willing and almost as often fully competent to render laboratory service when requested so to do, but it has not aggressively and persistently gone out in search of work nor has it adopted policies that have rendered it in any great measure a serious competitor of commercial laboratories.

There are several reasons why the latter are able to secure business when the hospital laboratory does not exist. Frequently the commercial laboratorian has located his workrooms in buildings patronized generally as offices by physicians. Moreover everything has been done to invite the patronage of the clientele. A call on the telephone will quickly bring a messenger for the specimen. In some instances, within a few more minutes the result will be telephoned to the office of the doctor, even before the patient leaves. Frequently the hospital laboratory is at some distance from the section of the city in which physicians have their private office. Every community has its "doctors'

row." The transportation of the specimen is difficult, and before the result of the study can be secured from twelve to twenty-four hours usually elapse. Frequently the physician is required to send his patient to the hospital for the collection of the specimen, or he is forced to furnish his own container and to act as the messenger to deliver it to the hospital. It is to be expected, therefore, that the hospital will lose this type of business unless it intelligently and persistently competes for it.

There is no excuse for the hospital to continue to remain aloof in such matters and to bemoan the fact that its income is not commensurate with the excellence of the service that its pathologic and specialty departments have to offer. In many instances the hospital should arrange for a messenger service whereby at certain stated periods during the day the offices of physicians are visited for the collection of urine, blood, gastric and other specimens. In addition the hospital should furnish convenient containers for such specimens. There is no reason why the hospital should not render as prompt a service as does the commercial laboratory. When this is not done, it is usually the result of lack of foresight, of sound business sense and of the recognition of the financial and service possibilities of such a service.

Moreover the director of the hospital laboratory can often provide a consultant service in addition to merely preparing a report and this should prove invaluable to the community physician.

It seems that the hospital laboratory should be able to compete in price with the commercial laboratorian. A price list published by a successful clinical laboratory catering to the profession of an Eastern city follows:

Urinalysis:	
Chemical and microscopic (quantitative)	$ 1.00
Tubercle bacilli	2.00
Gonococci	2.00
Total nitrogen	3.00
Uric acid, urea, ammonia, each	3.00
Sputum:	
Tubercle bacilli	1.00
Bacteriologic:	
Cultures for diphtheria	2.00
Other cultures	$ 3.00 to 5.00
Animal inoculation	10.00 to 25.00
Gastric Contents:	
Quantitative chemical and microscopic	3.00
Feces:	
Complete examination, chemical and microscopic	5.00
Cerebrospinal Fluid:	
Wassermann reaction	5.00
Cell count	2.00
Blood:	
Count of red and white corpuscles and hemoglobin	3.00
Differential leukocyte count	5.00
Coagulation time estimation	2.00
Chemical Analysis:	
Total nitrogen, nonprotein nitrogen, urea, creatine, creatinine, carbon dioxide tension, cholesterol, sugar, each	5.00
Serologic:	
Wassermann reaction and Hecht-Gradwohl	5.00
Widal reaction	2.00
Blood cultures	$5.00 to 10.00
Basal metabolism	10.00

No valid reason is believed to exist that would prevent the laboratory department of the hospital, with many of its overhead expenses absorbed along with those of other departments and with no expense for rent, heat or light, from underbidding the commercial laboratorian. This is usually not the case, however, and as has been intimated the cause is either an inadequate service or a lack of business sense in bringing about the sale of laboratory work to the physician and to his patients. There are some practical angles to this matter. Hospital laboratories are notorious for their inaccessibility to the public. Often when a patient is sent to the hospital for the collection of a blood specimen or the carrying out of other minor laboratory procedures, he finds it difficult even to find the laboratory or the technician to whom he is referred. As a result a patient frequently receives an unfavorable impression as to the hospital's real desire and ability to smooth his always difficult path.

Nor is it beyond the pale of practicability for the hospital to announce that it is prepared to send a technician to the home of a patient for the performance of laboratory work when this is necessary. The commercial laboratorian offers prompt service in this respect. When specimens have been obtained, immediate notification of the physician by telephone of the result, followed by the prompt mailing of the report tends to create an appreciative clientele.

Many institutional laboratory report forms are untidy in appearance and too brief and they do not command the respect that they should. This is not the case with the more businesslike reports of the commercial laboratorian. The laboratory director may even upon request elaborate somewhat upon the probabilities as to diagnosis and the indications for treatment, which he learns from a study of the specimen submitted.

Finally, if the laboratory of the hospital is to build an income producing department, it must offer a better service, a lower price and a more

definite evidence of willingness and business acumen than it has hitherto done.

Many of the remarks that have been made relative to the hospital laboratory are applicable to the physiotherapy department. Frequently to be found in an out-of-the-way, poorly ventilated and improperly equipped area, this department, in the eyes of the public, fades into insignificance when compared with the businesslike and even luxurious atmosphere of the suite of treatment rooms usually offered by the successful physiotherapist. Hospital patients are often forced to accept an inadequate physiotherapy service offered by the hospital. Patients of the practicing physician, who are not undergoing hospital care, have a greater choice. The polished professional attitude of the physician practicing physiotherapy extramurally is conspicuous by its absence when a visit is paid to the hospital physiotherapy department. Too frequently the patient meets a technician or an assistant to the director and hence often finds no one to whom he can pour out his description of the pain and discomfort that have been produced by the joint or muscle disease for which he seeks treatment. The institutional physiotherapy department is too often characterized by an inordinate degree of machinelike functioning—by a tendency to treat patients as units and not as individuals.

We Must Look to Our Laurels

The hospital if it hopes to compete with others in this type of treatment must certainly see that its physiotherapy department is accessible. It must provide equipment for giving cabinet baths, electrotherapy, hydrotherapy and colonic irrigations. These facilities must be equal to or must exceed in completeness that of the private physician. Adequate space for rest rooms and for privacy as well as facilities for providing lunch for patients if they want it, are methods of increasing the patronage of this department. The director of the physiotherapy department must command the scientific respect of staff members and must be able to sell the idea that he can provide a curative service. Rate cards must be so drawn up as to compete with those of the private physiotherapist. The dissemination of information that as complete facilities for performing this type of work are available at the hospital as are found in the average commercial hydrotherapy establishment often will bring to the institution patients suffering with obesity, intestinal stasis, myalgia and the like, who perhaps normally find their way to public establishments.

Many physicians have equipment in their offices for the performance of basal metabolic estimations. Since the patient should be required to rest for a number of hours before this test is undertaken, doubt as to the accuracy of such studies has been expressed. The hospital should be able to furnish this type of service in a more scientifically accurate degree than does the private physician. A flat rate for the performance of this test might include a night's stay in the hospital, with perhaps breakfast following the test. The first named requirement would be difficult for the physician to supply in his office. Here again the patronage of the department can be increased by a wide-awake director who is able to demonstrate the possibilities of his work to his fellow staff members.

The electrocardiographic department also possesses financial possibilities. On the desk of every community physician may be placed an announcement setting forth details as to the methods by which this and other services may be secured and including the cost of these services to the patient. Most physicians desiring an electrocardiographic study, for example, have little idea as to when the patient may be sent to the hospital, how long he will be required to stay and the cost of the service. Here again the hospital should pursue the policy of seeking business rather than awaiting applications for the sale of this valuable and often indispensable service.

In the next article will be discussed practical measures whereby the x-ray, dietetic and surgical departments may cater to the needs of the community and its physicians.

More Mental Nurses Needed to Relieve an Acute Situation

That an acute shortage exists in the number of nurses needed to care for mental cases is sharply emphasized in an editorial in *Mental Hygiene Bulletin.* The demand for mental nurses far exceeds the supply. It is estimated that 95 per cent of the nursing profession are without training in psychiatry or mental hygiene, although there are more patients in mental hospitals to-day than in all other hospitals combined and the need for specially trained nurses is great.

"Some means must be found immediately to enlarge the psychiatric nursing personnel and relieve this situation," the editorial further emphasizes, as it goes on to point out that one way would be for those engaged in mental hygiene work to point out to promising young women the opportunity this field offers for a socially constructive and financially beneficial career.

Editorials

False Economies Mean Faulty Service

IT IS the part of good business and efficient management for the superintendent always to take advantage of the "best buys" that he can find, and to this end the astute administrator in these trying times is confronted with more than an ordinary situation.

Costs of many commodities and supplies used in the hospital are lower than they have been in years and our reputable supply houses are passing these advantages along to their customers. However, a note of warning is in order.

Because the buyer is looking for lowered costs and because honorable merchandisers are passing on to their customers every price advantage, some unscrupulous dealers and manufacturers are pushing the sale of inferior merchandise at prices that seem to be unbelievably attractive, but which in reality are exorbitantly overpriced when the real deciding factor of quality is considered. Rubber goods that are shopworn and shoddy, instruments that are "seconds," foods that are "rejects" and "culls," linens that will not stand the simplest tests, and many other items used in every department have been dumped on the hospital market recently, and while the prices are tempting the purchase of them would be a liability.

While a favorable price of standard articles is always to be sought, and is generally available because of reduced manufacturing costs, the price should be only one of the deciding factors in purchasing—reputation of the seller, quality of the merchandise, and responsibility of those behind the manufacture and sale of the articles are as important and in many cases are more important than the factor of price.

Let each hospital economize by all reasonable means in purchases, but let each remember that the standards of hospital service must not be lowered by cheap and shoddy goods—that those merchants and manufacturers who have seen us through many years of honest service are not forgotten now, and that the claims and promises of the "fly-by-night" bargain peddler are not given credence.

If you are offered what appears to be standard merchandise at ridiculous prices, do yourself the service of at least calling in the reputable and dependable merchant so that he may present his wares and his side of the story. His price in comparison may surprise you.

False economies mean faulty service to the patient, and the ultimate result of this combination is a loss of community and medical staff confidence. Quality plus reasonable prices, plus an honest reputation and continued services, mean real economy and contribute to the hospital's efficiency in the end.

A Crusader for the Injured Worker

WHEN the first of our many workmen's compensation laws was promulgated twenty years ago communal leaders hailed with joy the advent of this kind of legislation, because it ushered in a better era in the history of industrial relations in this country. The fundamental principles of social insurance are now universally recognized and their application is indeed considered an index of social progress, regardless of political differences.

It was expected that legislative protection for the injured worker would eliminate the older system in which he could be indemnified only if he could prove wilful negligence on the part of his employer—and then share the indemnity with his lawyer—or become an object of charity. It is estimated that seventeen million workmen are now insured against the consequences of industrial accident through the operation of workmen's compensation laws, which prevail in all but four states. These four states are in the South. More than one hundred and fifty million dollars in benefits have been distributed during the last year. Since insurance companies would discover that preventive medicine pays and that industrial accidents might prove costly under the terms of the workmen's compensation law, it was hoped that a considerable addition to the number of mechanical and other safeguards in the industries would be made with a view to reducing the relative number and severity of industrial accidents.

It was expected from the start that the treatment of industrial accidents under the provisions of the workmen's compensation law would be undertaken in the best traditions of the medical profession. The injured workmen, in whose behalf the laws were passed, were to receive first consideration, a principle that is directly opposite to the one taught in military surgery where the primary object is victory and where the individual

soldier is judged from his value in its achievement.

Unfortunately, however, strongly commercial influences have cast their shadow over the medical management of workmen's compensation cases and a number of changes are imperative if the original spirit of these laws is to prevail. As Howard S. Cullman points out elsewhere in this issue, the philanthropic public is made to contribute in hospital service a considerable part of the cost of the medical care of the injured employee to the employer and to the stockholders of the insurance companies, a contribution the law was intended to eliminate. This is surely the survival of the charity of an earlier day.

Commercial clinics have been established directly or indirectly by the insurance companies, the "lifting" of cases from reputable hospitals and practitioners has become a common practice—and both have reason to dread the compensation courts—the ubiquitous adjuster has far overstepped his bounds, and a system has developed wherein the worker in disputed cases must depend upon the biased testimony of the hired physician of the insurance company.

Into the lists Mr. Cullman has entered with the spirit of the crusader who is determined to see that justice is done to the injured worker and to the medical individual or institution that is properly equipped to take care of him and, furthermore, that the financial burden of his treatment is placed where it properly belongs. Every forward looking citizen who is eager for social betterment will wish success to his efforts.

What Are Your Problems?

IT IS not necessary for one to be old in the hospital game to remember when the demands for all kinds of new equipment and apparatus were comparatively few; to remember when the average general hospital consisted of large open wards and occasionally a few rooms for isolation purposes and private patients.

Like a plant struggling up for the rays of the sun, the hospital world is alert to all that is new in methods of treatment and devices for the comfort of their patients. Much of the apparatus developed and many of the methods of treatment introduced from year to year go into the discard. How is the superintendent to know where to draw the line when it comes to spending the hospital's money for new developments? The answer to this important question that the superintendents of hospitals of all sizes are called upon to decide may be found at the annual convention of the American Hospital Association. These meetings are designed with no other purpose in mind than to solve, if possible, the numerous problems confronting the hospital field. They are attended by the persons to whom the present hospital development owes its existence, persons whose experience is as wide as our country is large and who are anxious to be of service.

What are your problems? What can these men and women do for you, these men and women who have long since stopped going to conventions to see what they can get that may be of use to their own institutions, but who go largely now to see what they can leave that may be of use to others?

Send a description of your problem to the president of the association and, if possible, you will be given an answer sometime during the meetings to be held at Toronto, September 28 to October 2.

Providing Adequate Nursing

SOME services that the hospital offers do not lend themselves to either quantitative or qualitative measurement. Nor can the individual patient's estimate of their adequacy or inadequacy serve as a guide to those in authority as to the success of a current administrative policy.

The cost of providing nursing for the hospital patient who does not require or is not able to purchase special nursing service is considerable. Moreover, the educational obligations of the hospital that conducts a school for nurses cannot to-day be looked upon as the mere ethereal visionings of an impracticable theorist. They are very real and very costly.

But the amount of nursing service that is actually delivered at the patient's bedside is not always accurately reflected by the total number of individuals in the school. Supervision of the work of the student nurse by a more seasoned graduate in nursing is essential both for the safety of the patient and for the welfare of the student. But in some schools for nurses there appears to be a tendency to stress unduly the need for the education of the nurse while in reality it is only a fortunate by-product that the nurse receives as she cares for the patient.

It is a fatuous and wholly unsatisfactory endeavor to attempt to draw up any numerical formulas with a universal application as to the optimum or even the minimum number of patients for which each nurse may care. The arrangement and size of buildings and wards, the amount of supervision available and even the individual capabilities of the nurse are all considerations that prevent the application of any general rule to this problem. Moreover, it is probable, in consideration of the time

required for classes, recreation and meals, that usually not more than six-tenths of the student nurse's time is spent in performing actual nursing duties.

The attention of the nursing ultra-educationalist it seems must often be called to the commonplace but practical fact that a shortage of funds is a chronic complaint in the average general hospital. Perhaps this is one of the best arguments in favor of the rigid separation of the school for nurses and the hospital. Yet, even under the present system of conducting these schools, none will deny the need for the presence in the hospital of an adequate number of pupil and graduate nurses. Nevertheless, there must be a just and equable division of resources available, each department economizing in the same relative degree.

Adequate nursing is purely a relative term. In the last analysis the physician must be the one to answer this question.

Shall We Have State Health Insurance?

A FEW years ago when the first hue and cry was raised as to the high cost of medical and hospital care, group health insurance was offered as one of the more visionary solutions and not given much consideration. Yet to-day we find the Canadian government contemplating state health insurance and the Royal Commission of British Columbia preparing to submit a report leading to enactment of a compulsory system of health insurance.

True, state health insurance is not new. It has been at work for some time on the continent and in England, with quite satisfactory results, we are told. But Canada and the United States are of a different temperament from old world nations. The question is, will their peoples, nurtured in independence, relish the paternalism that state health insurance implies? This question seems to have been answered in the affirmative so far as British Columbia is concerned, for C. H. Gibbons, secretary of the Royal Commission, reports that municipal corporations of the province are 100 per cent in favor of state health insurance and the Canadian Manufacturers' Association have given a ten to one endorsement of the plan. They have been won over largely on the argument of greater economy to the employer.

Under the plan set forth by Mr. Gibbons, in his article on page 63 of this issue, the employer pays a "fair proportion of necessary premium charges" and the state administers the fund. In actual practice will this prove an economy to the employer as compared with voluntary health insurance under the complete direction of the commercial firm? Mr. Gibbons points out that the employer pays no administration costs under state health insurance. It should not be overlooked that administration costs must be borne by taxation and that this financial burden reverts to the employer to a certain degree. Moreover there is the danger that though the state or provincial board is of a so-called nonpolitical character a few unscrupulous members may mismanage the fund. Even if the administrators are conscientious they still have not the incentive to effect desirable economies such as we find in executives of business corporations where competition is an element. Then again, if the employee is privileged to have unlimited medical service there is the likelihood that he will abuse this right to a greater extent under state administration of health insurance than if the funds were expended by the firm with which he is connected.

On the other hand, the employer has much to gain—how much is difficult to reckon—from state health insurance through fewer unproductive days of labor, greater efficiency of the workers, and the decreased labor turnover that are the certain result of improved health among the employees.

In short, before state health insurance is accepted, all its ramifications must be studied so that the plan will be fair to capital and labor.

There is no question but that the hospital world will benefit from state health insurance if it is administered even with reasonable efficiency. It means practically the elimination of charity cases, which have caused hospital charges to mount so rapidly. It means the reduction in bad debt losses to the hospital. There is, however, one all important essential that should be provided for the protection of the medical and the hospital professions. That is, the employee should be allowed a free choice of physician and hospital, with certain limitations for his own protection. The physician he chooses should be a graduate of a recognized medical school, ethical, experienced and of good judgment (in other words, he must know his limitations). The hospital that he selects should be of a type that provides diagnostic and therapeutic facilities now recognized by the medical profession as essential to scientific care. Aside from these limitations, the employee should have a choice as to the kind of medical and hospital care he desires. If such choice is not permitted, state medicine and the elimination of the individual practitioner are certain to follow. The results in turn can only react to the harm of the medical and hospital professions and of the person who is insured.

Abstracts of Hospital Literature From Foreign Countries

A Department Conducted by E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

THE CARE OF INFECTIOUS DISEASES

By E. A. Koch, Medical Director, Municipal Hospitals of The Hague

The point of view and the resulting regulations concerning the prevention and spread of infections have changed considerably in recent years. During the last epidemic of smallpox in this city the cases increased in a manner that could not be explained until the chief physician of the hospital noticed that the spread of the disease was not due to contact infection from isolated cases as much as to the existence of abortive cases that were walking about. During the epidemic nurses were isolated in the neighborhood of the wards and remained under observation ten days after the nursing of the smallpox patients was completed.

Doctor Koch does not fear air infection of smallpox and regards the English regulations as to the distance between infectious pavilions and private houses somewhat exaggerated. He nevertheless recognizes the need for keeping a respectable distance from cases, thus taking into account the layman's fear of infection that may lead to panic during epidemics.

In former times nurses who cared for infectious cases were generally kept under isolation. They are, however, now permitted to go about their work without any special efforts at subsequent disinfection.

In the course of his remarks Doctor Koch attempts to answer a few interesting questions in regard to the spread of infectious diseases. What should be done in the event of an outbreak of scarlet fever in a children's surgical ward? After immediate evacuation of the infectious patient, everything that had been in contact with the patient should be sterilized. The patients and nurses who were exposed should be kept under strict watch during the period of incubation. Outbreaks of diphtheria in children's wards scarcely ever occur, since bacteriological examinations of the throats of children are always made shortly after admission, nor does Neisserian infection spread in the girls' wards, since adequate precautions to prevent this are taken when the girls are admitted.

In the case of chickenpox or measles it is more difficult to control the spread of infection, since this takes place, as a rule, before the diagnosis is established. After the removal of the patient from the ward no children are admitted for three weeks unless they have acquired immunity from a previous attack.

In Holland patients suffering from erysipelas are admitted only to infectious pavilions and not to the medical wards, as was the practice formerly.

Statistics

The population of Holland is 7,500,000. There are 287 general hospitals with 25,129 beds. There are 117 infectious departments with 3,044 beds. There are 29 sanatoriums with 2,559 beds.

ST. ELIZABETH'S HOSPITAL IN TILBURG

By Dr. S. F. P. van Buchem, Administrator

The old hospital in Tilburg was interesting historically. In this hospital the nursing of patients was performed by nuns in wards with cubicles constructed in the fashion of a former day. The old building has now been abandoned and a new one of modern construction is in use. It consists of two-story pavilions communicating by covered corridors. The ground floor plan shows a quadrangle with offshoots to the various pavilions. The large inner court is entered directly from the outside (main entrance). In a separate building on the hospital grounds there is a low pavilion for infectious cases.

The plan indicates a practical group which permits independent functioning without the great distances that are associated with the pavilion plan.

The ward building consists of two wards with accommodations for ten and twelve beds respectively. The wards are separated by the auxiliary service rooms while additional service rooms are projected in the direction of the main corridor. The editor thinks that the construction of the

wards is not entirely up to date, as they have a certain lack of privacy—a fault which the editor remarks is common in Holland, where the rights of the ward patients with regard to privacy are not given full consideration. On the other hand, private patients receive every possible comfort.

Ground plans and photographs illustrate the description.

THE EDUCATION OF NURSES IN CERTAIN NURSING FUNCTIONS

The common practice is to select candidates for vacant positions from experienced candidates who, if they have the required capacity, will rise from post to post. In Holland there is no theoretical education for the positions higher up other than that required by the state for obtaining the certificate of graduate nurse.

A report prepared by a committee of three experts recommended the following educational scheme: the theory and technique of the more difficult nursing procedures; the care of dressings, instruments and nursing equipment; the theory of the more difficult methods of research; the education of students; the psychology of patients and the problem of the patient and his family; the administration of a sick ward; the housekeeping of a sick ward; the knowledge of certain fundamental principles of sociology; social work in connection with the sick ward; occupational therapy; after care; dietetics and the preparation of food; hospital economy; the ethics of sick nursing; the history of sick nursing; the main principles of social hygiene; the technical departments of the hospital; fire prevention and similar routine problems of the hospital.

The committee recommends that a three or four months' course be given once a year at a central part of the country where it will also be possible to arrange for visits to adjoining hospitals for demonstration and for practical exercises.

OCCUPATIONAL THERAPY AND INSTRUCTION

By Doctor le Rütte, Director of the Asylum at Deventer

Doctor le Rütte expresses surprise at the checkered career of occupational therapy through the last few generations. It was put into practice by laymen several centuries ago and has since been applied with ups and downs during periods when enthusiasm for this kind of treatment rose and fell.

Some twenty years ago Doctor le Rütte introduced occupational therapy into his asylum at a time when no other medical man in Holland attached importance to its application. It has proved to be so successful that the medical staff now takes an active interest in the work. Doctor le Rütte finds no reason for the prevailing impression that occupational therapy requires a large staff and a considerable outlay of expenditure. He finds that the trick consists in organizing the work so that every member of the hospital personnel will assist in the work. In principle he thinks that the nursing personnel should be made conscious of the social, economic and educational value of occupational therapy. The author goes on to tell of his correspondence with Doctor Simon, the German specialist in occupational therapy, and ends by recommending that occupational therapy be introduced in the curriculum of schools of nursing.

FIRE PREVENTION IN HOSPITALS

By A. G. Förch, Chief, Fire Department of Amsterdam

Mr. Förch emphasizes the following principles in fire prevention: (a) prevention by means of rules and regulations concerning the building and its equipment; (b) fire fighting equipment; (c) installation of an adequate alarm system for inside and outside calls.

The municipality of Amsterdam has a number of laws on this subject which are concerned with the following: (a) the number, location, dimensions and arrangement of all entrances and exits; (b) the composition of ceilings; (c) the number, location, dimensions and composition of staircases and corridors; (d) the elevators; (e) the heating and lighting arrangements and the system of ventilation; (f) fire escapes and fire extinguishers.

THE BUSINESS MANAGEMENT OF STATE HOSPITALS IN THE DUTCH EAST INDIES

By W. F. K. Verhoff, Administrator, Semarang

The hospitals in the Dutch colonies are state institutions, except those that are conducted by missionary organizations and those conducted by the large companies that cultivate tobacco, rubber and sugar. In an earlier issue the relation of these hospitals to the public health of the Dutch East Indies was discussed from the standpoint of the mortality rate, which now compares favorably with the rates that prevail in Europe.

During the last few years the department of public health has reorganized the accounting systems under its control based on the best principles of commercial bookkeeping. As a result accurate financial statistics about income and expense are now available, as well as a survey of the real assets of the institutions.

NURSING AND THE HOSPITAL

Conducted by M. HELENA MCMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

Safeguarding the Health of the Student Nurse

By H. L. SCAMMELL, M.D., C.M.
Field Representative, American College of Surgeons

DURING the last ten years hospital executives have been devoting more and more attention to the health of the nursing staffs in their institutions. New and better nurses' homes have been built with better facilities for healthful exercise. The hours for work have been shortened and in general it is recognized that actual drudgery is not essential to the adequate training of a nurse. Larger hospitals have an elaborate program for selecting the pupils for their training school and for safeguarding their health after admission.

Obviously a fourfold responsibility is involved.

The first responsibility is to the general public, as a public health measure. It is the duty of the hospital to take the lead in all measures, preventive as well as curative, that will benefit the health of the community. There is, second, an obligation to the patient. The nurse cannot give efficient service to those she cares for if she is unwell or under par physically. Moreover, the hospital in most cases would be morally if not legally responsible to a patient who contracted a disease from one of its pupil nurses. Again the hospital owes a considerable responsibility to the nurse herself and to her relatives in safeguarding her health while she is under its guardianship. The general public has long realized this and justly or unjustly blames the hospital if a sister or a daughter is forced to abandon her training because of a breakdown in health.

Lastly, the hospital has a duty to itself. A weak link in its chain of endeavor imperils the whole. If that link is an unreasonable amount of illness among the nurses, varying from the common cold to pulmonary tuberculosis, the efficient conduct of the whole internal economy of the institution is endangered.

How then can we meet so great an obligation? Primarily, by having sympathetic cooperation between the staff of the hospital and the management, by a clear-cut system of selecting pupils and by providing satisfactory living conditions and proper care during illness.

The first step in such a system is selection. Many hospitals have developed a method of selection that is admirable. Others are negligent in this respect. When there is any doubt about the suitability of a candidate her application should be rejected. To many this may seem the height of cruelty, but it must be remembered that the girl is presenting herself as an aspirant to an arduous profession. In 90 per cent or more of all cases she is looking forward to it as a means of obtaining a livelihood. Would a hospital be doing her justice if it accepted her and as a result of her work a breakdown occurred and she became an invalid, when in some less strenuous profession she might well have continued to be a useful and self-supporting person?

A personal interview is the ideal method of selection. The second best is to send the girl a questionnaire and ask for a full-length photograph. Deformities of the limbs or trunk, strabismus, harelip, cleft palate and similar conditions should definitely rule out the candidate. I do not think that applicants who are under 5 feet 2 inches or over 6 feet in height are desirable, but the ques-

tion must be settled according to the qualifications of the candidate as a whole. Other characteristics too numerous to mention may be revealed during such an interview.

Unless peculiar local conditions obtain, it is desirable that immunization measures be carried out at home by the family physician during the period between the acceptance of the application and the time when the pupil is called to present herself for work. A form recording the immunization measures desired by the hospital, with the dates on which they were completed by the physician, and his certificate to that effect, is useful. This procedure is of advantage because the immunization is complete when the pupil begins her training and is thus effective during the period when her lack of knowledge renders her most susceptible to infection, and because it is done while the girl is in her own home by the family doctor who naturally possesses the confidence of the family. Any temporary indisposition resulting from the inoculations is readily explained by him and the girl does not lose the time or suffer so greatly from the homesickness that often makes the probation days stormy. Vaccination against smallpox and typhoid, with preventive measures if the Schick and Dick tests are positive, should be done as a routine. During this period also a careful examination of the teeth and repair work when it is necessary are essential. If the tonsils are definitely infected removal before admission is advisable.

Who Should Make the Physical Examination

Every hospital with a training school should have two or more physicians definitely responsible for carrying out the routine physical examinations of the nurses on admission. They may summon to their aid such specialists as they desire and have available full x-ray and laboratory facilities. A statement from the family physician of any relevant facts in the girl's history aids them in this examination. The practice of obtaining a certificate of (nearly always "excellent") health from the family doctor may be reasonably dispensed with, for though he may be conscientious to a fault he often has not available complete diagnostic facilities without subjecting the candidate to considerable expense.

In carrying out the preliminary examination the following measures are essential: a complete urinalysis from a catheterized specimen; a complete blood picture; a throat swab, smear and culture; the Wassermann and Kahn tests; examination of feces for occult blood and parasitic ova; x-ray examination of the lungs and a cardiogram; a general clinical examination of all systems, positive and negative findings being carefully recorded.

Much of this examination is routine, and once a system is developed the laboratory x-ray work can be arranged through the head of the training school during the first few days, the physicians having these data available when they make their physical examination at the end of the first week. Thus, after only a short period in the hospital many of the unfit can be weeded out, often making it possible to fill vacancies from waiting candidates, with little loss of time.

Judging a Probationer's Fitness

By subjecting the nurse to observation during the probation period much valuable information may be gained as evidence of physical fitness or of incipient disease. Probationers are as a general rule given more time off duty than is allowed them at a later period in their training. If undue fatigue is noted when the girl is doing routine work, this point is weighed in the final check.

Probationers should be weighed weekly during this period and always with the uniform on. A gain over or a maintenance of the admission weight is satisfactory, as is also a slight loss followed by a gain, but a persistent loss calls for further inquiry. The girl's appetite for meals, particularly breakfast, can be checked with fair accuracy by the dietitian through the dining room staff. Poor appetite for the morning meal is often indicative of a toxemia. Educators generally note mental and physical improvement following the eradication of focal infections. Mental apathy may be an indication of such a focus.

A week before the probation period is ended the medical examiners with all the recorded data before them should thoroughly review each case and if satisfied with the probationer's fitness to pursue her training should certify their approval in writing. However, if any doubt remains in their minds they may demand further laboratory or x-ray examinations and make their final decision before the last day of the period is completed. Further examinations may be arranged, but anything short of the foregoing scheme cannot be considered adequate. The clinical findings must be carefully correlated with the laboratory findings in all cases, and no pronouncement should be made on either alone. It is also necessary that laboratory examinations should be made by a trained technician and interpreted by a pathologist, who preferably should do all but the routine work personally.

A well conducted training school gives at least two and many give three hours a day for rest periods. Regardless of how many other things the nurse may wish to do during this period she

is well advised to devote at least one hour to rest and one to recreation. Rest that is considered adequate is rest in bed, with the door shut and the windows open. The nurse must be alone during the period and if she cannot sleep she should at least lie still with her eyes closed. Reading should not be indulged in.

In many large hospitals and in some smaller ones recreation of a special nature is now provided for nurses. While a gymnasium is advantageous it is not essential. Walking can be indulged in by all, and most communities offer facilities for tennis, swimming and seasonable sports of one kind or another. An effort should be made to suit the exercise to the physical development and reserve of the individual, and the exercise should not be continued to the point of actual fatigue.

Everyone Needs Eight Hours' Sleep

An adequate period of sleep cannot be too strongly stressed. The pupil nurse must understand that she is engaged in arduous training at a time when she is completing her physical development. Rest and sufficient food and exercise will best ensure her resistance to infection. "Late leave" once a week is sufficient. The nurses' home should be quiet by ten-thirty at night. Eight hours' sleep in a comfortable bed is indispensable.

The relative merits of cafeteria or table service do not now concern us. Suffice it to say that well cooked food, tastefully served and in sufficient variety to stimulate the appetite is the right of every pupil nurse. While whims should not be encouraged, pronounced preferences, if not detrimental to health, may be indulged. For example, a girl may prefer milk to tea or coffee. As a degree of constipation seems prevalent among nurses, stewed fruits, bran muffins and syrups should be included in the dietary. Fresh fruits and vegetables are always necessary. It has been found of benefit to devote one week a month to an "appetite census," the dietitian reporting "appetite minus" cases to the training school office.

Each nurse should be weighed every month by an official of the training school. She should always be weighed in uniform and on the same scale to exclude variations and the weights should be carefully recorded. Moreover they should be studied and utilized. They may be graphically recorded with great advantage on a sheet of squared paper which may be kept in each nurse's folder for the thirty-six months of her training. The months should be plotted horizontally, the weight vertically. An interesting feature that may be added is the normal weight line in red ink for each nurse according to her age and height, such as can be obtained from any work on clinical medicine. Following the pupil's admission there is generally a loss of weight. Before the third month is over the pupil may show a gain which is maintained up to the sixth or seventh month. There may then be a loss of a few pounds, after which the weight fluctuates slightly from month to month. Sudden and gradual but constant losses of weight call for immediate and searching examination.

The nurse is entitled to attention if she is unwell. The proper selection of pupils will weed out 90 per cent of the grumblers and complainers. Without being encouraged in undue introspection, the pupil should be advised to report at once any unpleasant symptoms she may notice in her health. One or two malingerers may develop but it is a wise precaution to investigate such complaints.

The foregoing procedure eliminates self-treatment on the part of nurses, a habit generally prevalent and too little recognized in its far-reaching results. Cough mixtures, laxatives and other drugs are freely partaken of to relieve a symptom the basis of which may be serious. In hospitals where there is inadequate supervision of narcotics, a few known and doubtless many unknown drug addictions have been formed. All self-treatment by the nurses should be severely discouraged.

Clothing suitable to the season should always be worn by nurses, especially when the nurses' home is some distance from the hospital. Rain, snow and slush as well as a sudden change from a warm building to an extremely cold outside temperature when the nurse is not adequately clothed are to be provided against.

When a Nurse Is Ill

Sooner or later despite all care on her own part and on the part of her supervisors, the pupil nurse may become ill. When this happens the nurse should be allowed to choose her own physician, provided he is a member of the hospital staff. Diplomacy demands this. Safety demands that it be an established rule that before an operation is performed and in any event within the first twenty-four hours of the nurse's illness the attending doctor have in consultation with him a man definitely delegated for the purpose by the management of the hospital.

If nursing is required for a period longer than twenty-four hours, it should be of the graduate type or carried on by a senior undergraduate nurse under the immediate supervision of a graduate. It is understood that this is special nursing.

The nurse should be under exactly the same restrictions as to visitors and general hospital rules as any private patient. Complete case

records should be kept in the regular way. These records should be filed in the training school office until the nurse graduates, when they should be entered in the regular hospital record file, a folder in numerical rotation having been reserved there.

The nurse is entitled to at least one daily visit from her attending physician. It is the duty of the hospital to insist upon this. A sick nurse should never be required to pay for any part of her treatment, or for laboratory and x-ray services. Except in the case of minor ailments of brief duration the patient should not be cared for in the nurses' home, that is, in her own room, but in special quarters designed for the care of sick nurses.

The probation period should feature a series of lectures on personal hygiene and on simple preventive medicine. These matters are too often neglected and such lectures, by clearing up ignorance and doubts on important subjects, will tend to lessen illness as well as to relieve mental anxiety.

Disorders of the menstrual function are common and distressing. "Hospital amenorrhea" of two months' and at times of longer duration is at times noted among pupils after admission. This is no doubt of compensatory origin, a natural precaution asserting itself during a period of unusual mental and physical stress. Time, good food, rest and exercise will establish the diagnosis of the etiologic factor present, provided careful examination does not definitely disclose it. Dysmenorrhea is also fairly common during the early months of training but regular habits, work and general good living conditions tend to eliminate this. In any case, medical supervision is advisable.

"Hospital sore throat" is an early symptom with many nurses. This is noted particularly in those in contact with septic cases, particularly postoperative empyema. It is generally mild, rarely lasting longer than forty-eight hours, and it seldom amounts to more than a simple pharyngitis.

Treating Specific Illnesses

Constipation is far too common and is in most cases primarily due to careless habits. It is too often treated spasmodically by the nurse with remedies from the medicine cabinet of the floor or department, and such treatment is as varied as are the twenty or more types of laxatives usually seen in such places. The lectures on personal hygiene together with the diet mentioned will assist nature in these cases and will often prove all that is necessary. Atonic constipation, of course, requires special treatment as do all persistent types.

The dread of hospital executives is the appearance of tuberculosis among the pupil nurses. Careful clinical and x-ray examination with a well taken history during the probation period will mean that at admission the nurse does not have the disease. Observation of her weight, appetite and general aptitude for work will aid in its detection in the incipient stage, while good food, rest periods, adequate sleep and exercise will increase resistance to it. When suspected of having tuberculosis the nurse should spend a week in bed under careful observation, the temperature, pulse rate and respirations being recorded on a four-hour chart. A careful general clinical examination and of course x-ray examination of the chest and sputum examination should be made. All possible sources should be investigated to ascertain the cause of the symptoms. It should be remembered that even before weight loss occurs disturbed digestion and palpitation of the heart are common complaints in the early stages of the disease and should be watched for.

Minor Ailments and Their Treatment

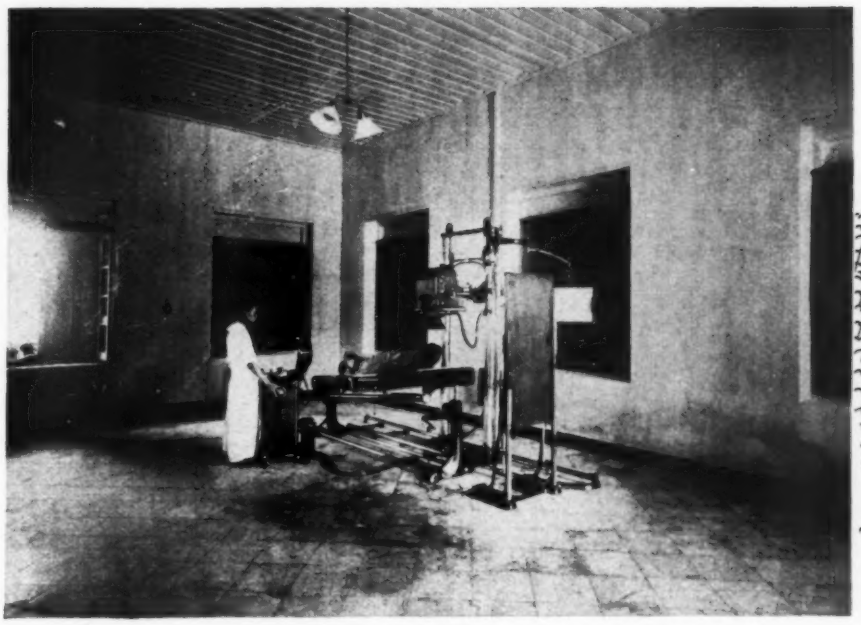
Burns, scalds, cuts, bruises and all the minor accidents to which flesh is heir are not uncommon in the hospital. It is the duty of the hospital to employ apparatus that reduces the chance for such accidents to a minimum. A nurse who continually drops things may be a victim of petit mal.

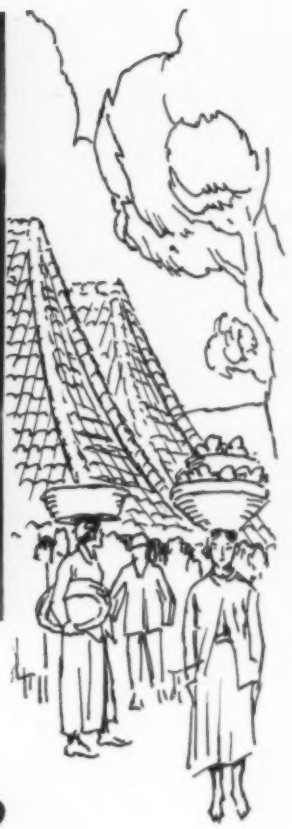
The infected finger is common and should be watched for. All cases should be regarded as serious. Prophylaxis is fairly simple and should be stressed by supervisors.

A Wassermann test should be made at least every six months and immediately before the pupil graduates or leaves the hospital for affiliation purposes. This is only fair to the hospital and to the nurse.

In closing it is only fitting to observe the influence of disciplinary measures on the pupil nurse's health. Punishment should be meted out wisely, each case being judged on its merits. It is unwise to deprive the nurse of her time off or to curtail her rest periods. Extreme humiliation inflicted on pupils whose mental equilibrium is not of the steadiest has ended in tragedy.

But why stress the question of punishment? If the nurse is carefully selected it will not often be necessary; if instructors are of the proper type it will be reduced to a minimum; if it is often required in the case of a pupil nurse, she has no place in the training school. If she cannot train herself to obey fairly simple rules of discipline and conform to generally accepted principles of right and wrong she is unsuited to grace the ranks of the profession to which she aspires.





Victor Model "A" Shock Proof X-Ray Unit in Pak Klong Lord Army Hospital, Bangkok, Siam

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NEWS OF THE MONTH

Pennsylvania Devises Collection Plan for Accident Cases

ONE of the most important movements that has been made in many years among hospitals and hospital associations was revealed in the report of the legislative committee at the tenth annual conference of the Hospital Association of Pennsylvania held in Philadelphia, March 24, 25 and 26. While in all parts of the country the outstanding perplexing problem has been the collection of bills for automobile accident cases, the Pennsylvania group has devised what is considered the first workable plan.

It has been proposed that, when an accident patient is brought in from an accident that is fully covered by liability insurance, and indications point that the hospital may not be able to collect its bill from the insured or the insurer, a judgment be secured against the patient for the care that he has received. The suit for the judgment will be brought with full knowledge of the patient and will be in the nature of a friendly suit. With the judgment secured, no award can be made by the defendant, his insurance company or other representative, without including the hospital bill. It would not apply unless a cash consideration for injuries suffered is received by the patient. This scheme of collection was claimed by those at the meeting to be a great boon to hospitals in all parts of the country.

Several other legislative matters were considered, one a lien law relating to the proceeds of any cash settlement which may be made in any accident injury cases and another a workmen's compensation act to provide forty-five days of hospital care instead of the thirty now allowed and to include the hospital rendering such treatment as "a party in interest" with standing before the courts to present its claim when the occasion requires. A third bill would reduce the collateral inheritance tax from ten to five per cent on philanthropic bequests. Some discussion was brought forth on the additional state aid proposed at the present session.

The president of the association, W. M. Breitinger, superintendent, Reading Hospital, Reading, presided at the opening meeting on the first afternoon. Invocation was asked by Dr. George W. Reese, superintendent, Shamokin State Hospital, Shamokin, and this was followed by an address by Dr. Wilmer Krusen, president, Philadelphia College of Pharmacy.

The vice-president of the association, W. S. Kohlhaas, superintendent, Harrisburg Hospital, Harrisburg, presided at the second session, at which reports of various committees were heard, and at which time Mr. Breitinger delivered his presidential address. This will appear in a later issue of THE MODERN HOSPITAL. This session was completed by a round table on extremely practical subjects, conducted by John M. Smith, director, Hahnemann Hospital, Philadelphia.

Trustees' Session Draws Large Crowd

The largest attendance at the conference was on Wednesday afternoon at the trustees' session which was presided over by William Shand, Lancaster, who is president of the Hospital Welfare Association, a new organization of hospital trustees in Pennsylvania. The first address was given by the Hon. Fred B. Gernerd, president, board of trustees, Allentown Hospital, Allentown, and the second by Francis J. Hall, president, board of managers, Harrisburg Hospital, Harrisburg. Discussion was lead by Dr. Bert W. Caldwell, executive secretary, American Hospital Association.

On Wednesday evening the annual banquet was held, at which time the address of the evening was given by Dr. W. Warren Giles, First Reformed Church, East Orange, N. J. A surprise followed this when Dr. Ross V. Patterson, dean, Jefferson Medical College, and president, state medical association, was introduced and asked to say a few words. Doctor Patterson, who has been intensely interested in the health and arts bill recently before the legislature, became so engrossed in his subject that he spoke for forty-five minutes. Among other things, he censured the nurses for not standing by the medical profession in the furtherance of this

TESTING, assaying, and standardizing Lilly Pharmaceuticals and Biologicals is the responsibility of the control laboratories which supervise each step of manufacturing.

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In specifying "Lilly" you are designating products made from the finest of carefully selected and tested crude materials by the most approved manufacturing processes and packaged under safeguards that assure you and your patients just what you ordered.

NEWS OF THE MONTH (Cont'd)

bill. This portion of his remarks was answered by Jessie J. Turnbull, superintendent of the Elizabeth Steel Magee Hospital, Pittsburgh, in which she explained the position of the nurses in the matter. President Breitinger brought the meeting to a close, but informal discussions on this subject took place in many parts of the banquet hall.

On Thursday morning Dr. William Hillegas, state board of medical education and licensure, Philadelphia, presided. This session was known as the doctors' session, and the first address was delivered by Dr. Donald Guthrie, chief surgeon at the Robert Packer Hospital, Sayre. Doctor Guthrie spoke on "The Significance of the Apparently Insignificant Matters in Hospital Administration" and his remarks were considered by many the most pertinent and practical that have been heard at any state meeting. Dr. W. Estel Lee, professor of surgery, graduate school of medicine, University of Pennsylvania, Philadelphia, opened the discussion. This was followed by a round table conducted by Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, Chicago. The report of the nominating committee was received at this time which resulted in the selection of John M. Smith, director, Hahnemann Hospital, Philadelphia, as president-elect.

The Thursday afternoon session was given over to nurses, with Marie C. Eden, directress of nurses, Presbyterian Hospital, Philadelphia, presiding. Two papers were given, the first by Esther J. Tinsley, president, Pennsylvania State Nurses' Association, and the second by Mary Roberts, editor, *American Journal of Nursing*. Elizabeth Miller, secretary, state board of examiners for registration of nurses, Harrisburg, then conducted the round table on nursing topics.

Minnesota Promises Diversified Scenery for Its Meeting

The Minnesota Hospital Association promises diversity in scenery as well as in program for its meeting to be held June 22, 23 and 24. The first day of the program will be held in Duluth and the second and third days in the beautiful resort of Lutsen, ninety-two miles from Duluth, on the banks of Lake Superior.

The trip from Duluth to Lutsen will be made over the Lake Superior International Highway, which winds through a region that has been celebrated in song and story since the coming of the Jesuits three centuries ago. On one side of the highway, along which the Minnesota delegates will travel, is majestic Lake Superior and on the other side mysterious wilderness that reaches for hundreds of miles north and northwest.

It is a journey that will linger long in the memory.

Radio to Emphasize Importance of Hospital Day

National Hospital Day will receive more attention from radio advertisers and radio chains than any other movement except the American Red Cross, according to a recent announcement by one in close touch with this field. More than a dozen national advertisers using the radio, most of them broadcasting from twenty-one to forty-seven stations, will, prior to May 12, pay tribute to the work of hospitals and mention National Hospital Day.

Hospital administrators and executives are urged to communicate with their nearest broadcasting station to learn when such announcements will be made in or near their community.

All of this publicity will help materially to emphasize the importance of hospital work and also should have its effect in increasing the number of visitors to all hospitals arranging a program for May 12.

Another important means of publicity for National Hospital Day is the distribution of advertising material for newspapers to more than 4,000 newspapers principally in smaller communities throughout the United States and Canada. This material should increase the interest of local editors in the programs of thousands of hospitals and obtain for the hospitals much greater and more effective display of news.

The Metropolitan Life Insurance Company has available for hospitals properly equipped, a moving picture illustrating scenes and incidents from the life of Florence Nightingale which will be sent free on request. Applications should be made to Dr. Lee K. Frankel, second vice-president of the company, 1 Madison Ave., New York City.

NEWS OF THE MONTH (Cont'd)

Hospital Leaders of Midwest Take Part in Two-Day Program

THE Midwest Hospital Association held its annual meeting at the Chase Hotel, St. Louis, on April 17 and 18. The opening session was presided over by the Rev. L. M. Riley, superintendent, Wesley Hospital, Wichita, Kan., and president of the association. Following the invocation which was given by the Rev. F. P. Jens, superintendent, Deaconess Hospital, St. Louis, an address of welcome was given by Dr. Curtis H. Lohr, commissioner, hospital division, Department of Public Welfare, St. Louis.

Student Nurses' Allowance Discussed

A most interesting afternoon program was conducted with E. E. King, superintendent, Missouri Baptist Hospital, St. Louis, acting as chairman. Much discussion followed the presentation of a paper on "Should the Student Nurse's Monthly Allowance Be Eliminated?" which was given by T. C. McGinty, superintendent, Oklahoma Baptist Hospital, Muskogee. The discussion was led by Estelle D. Claiborne, superintendent, St. Louis Children's Hospital, St. Louis, and was participated in by nearly all of the superintendents present. The second paper on the program was given by J. R. Smiley, superintendent, St. Luke's Hospital, Kansas City, Mo., in which he advocated the standard system for collection of hospital accounts. George W. Miller, superintendent, Morningside Hospital, Tulsa, Okla., opened the discussion, and this also brought forth the expression of many opinions. The last speaker at this session was Dr. Louise Ament, superintendent, Lutheran Hospital, St. Louis, who spoke on the activities of state board of nurse examiners.

The Friday evening dinner was presided over by Dr. Bert W. Caldwell, executive secretary, American Hospital Association, who acted as the toastmaster. The first speaker was Dr. Christopher G. Parnall, superintendent, Rochester General Hospital, Rochester, N. Y., who read a paper on "Problems of Hospital Service and Medical Practice." This was followed by an unusually able address delivered by the Rev. Alphonse Schwitalla, president, Catholic Hospital Association, on "The Interrelation in Authority Within the Hospital." The last speaker at the banquet was John A. McNamara, executive editor, THE MODERN HOSPITAL, who spoke on "The Workmen's Compensation Act." Excellent musical numbers were contributed during the evening.

On Saturday morning the Rev. R. D. S. Putney, superintendent, St. Luke's Hospital, St. Louis, acted as chairman. The first speaker was Miss Claribel A. Wheeler, director, school of nursing, Washington University, St. Louis, who discussed the findings of the grading committee and their effect upon schools of nursing. Dr. E. J. Lee, Jr., superintendent, City Hospital, St. Louis, was the second speaker, who discussed "The Value of the Pathological Department in the Education of the Intern." The third speaker was L. Eleanor Keely, superintendent, Boone County Hospital, Columbia, Mo., who spoke on "Personnel Necessary to Operate a Fifty-Bed Hospital." The discussion was opened by M. Ray Kneifl, executive secretary, Catholic Hospital Association, St. Louis. The session was closed by a general discussion led by E. E. King.

The last meeting was presided over by Dr. A. J. Weedn, proprietor, Weedn Hospital, Duncan, Okla. This session was given over to an interesting question box of practical subjects. The meeting ended with a business session and election of officers.

University of Mississippi to Build New Hospital

A new hospital at the University of Mississippi is to be built at a cost of $175,000, including $35,000 in equipment and a $10,000 medical library. The building is to be a part of the medical college.

NEWS OF THE MONTH (Cont'd)

Dr. Herbert O. Collins Dies in Fresno, Calif.

Dr. Herbert O. Collins, for nearly ten years director, General Hospital of Fresno County, Fresno, Calif., died suddenly March 25.

Doctor Collins was a well known hospital administrator, having been connected with the Minneapolis General Hospital, Minneapolis, the Winnipeg General Hospital, Winnipeg, Canada, the University of Iowa Hospital, Iowa City. He became widely known as a hospital executive while he was

serving as assistant superintendent, State Hospital for the Insane, Dayton, Ohio.

During his stay at the General Hospital of Fresno County, he built the institution up to the point where it is considered one of the model institutions of its kind in the United States. His most earnest efforts were directed toward establishing a ward in which unfortunate children of indigent parents would be given the same attention as that received by children of wealthy parents in private sanitariums. His sudden death came on the eve of the realization of his dream for a modernly equipped section for crippled children at the hospital.

Doctor Collins was in the past a frequent contributor to THE MODERN HOSPITAL.

Dr. Eugene B. Elder Heads Tennessee Association

Dr. Eugene B. Elder, superintendent, Knoxville General Hospital, was elected president of the Tennessee Hospital Association at its annual meeting held April 13 in Knoxville. The meeting was the second annual meeting held by the association, and was presided over by Dr. Henry Hedden, superintendent, Methodist Hospital, Memphis, president of the association.

An address of welcome was given by Mayor Trent of Knoxville, and a response to this was delivered by C. P. Connell, superintendent, Vanderbilt University Hospital, Nashville.

"The Duties of the Hospital Trustee" was the title of the first paper, which was given by John A. McNamara, executive editor, THE MODERN HOSPITAL, and which was discussed by many of those present. Dr. Bert W. Caldwell, executive secretary, American Hospital Association, delivered an excellent summary of hospital organization, in which he outlined briefly the qualifications and the duties of the various department heads. George D. Sheats, superintendent, Baptist Memorial Hospital, Memphis, was the next speaker, and he talked on the feasibility of flat rates in all hospitals and their effect upon reducing the cost of hospitalization.

A most interesting round table was conducted in the afternoon by Doctor Caldwell, at which about twenty practical problems were discussed. Following the round table, the members of the association were taken to Gatlinburg in the Smoky Mountains for a real Southern dinner served at the Mountain View Hotel. They were honored by having Mayor and Mrs. Trent as their guests. After a delightful ride back to Knoxville an evening business session was held at which the officers were elected. At this time the first three honorary members of the association were elected. They were Doctor Caldwell, Mr. McNamara, and Matthew O. Foley, editorial director, *Hospital Management*, who was not present.

The Community Hospital and Community Health

THE raising of community health standards goes hand in hand with the broadening activities of the community hospital. Through educational work with resident patients, out-patients and community contacts the influence of the hospital is far reaching.

Naturally such surveillance of the community leads to the attack of those abuses of right living which result in an ill-balanced metabolism—so frequently revealed through a diminished alkalinity of the blood and tissues due to an excess of acid products—acidosis.

"Phillips' Milk of Magnesia" promptly counteracts gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis. Thus its utility to the hospital and the community is exceptional. Its agreeable taste and appearance, its pronounced affinity for acids and its mild laxative action have found universal appeal and preference in hospitals.

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Hospitals are advised to insist upon "Phillips' Milk of Magnesia" which has carried our registered trade mark for over fifty years. Obtainable from druggists and supply houses everywhere in 4-ounce (25c bottles), 12-ounce (50c bottles) and 3-pint hospital size.

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NEWS OF THE MONTH (Cont'd)

Full Week's Program Planned for Hospital Social Workers

The American Association of Hospital Social Workers will hold its annual meeting as an associate group of the National Conference of Social Work in Minneapolis. The program opens with a luncheon and business meeting on Monday, June 15, at the University of Minnesota Hospitals, at the invitation of Paul Fesler, superintendent, and Frances Money, director of social work.

On Tuesday afternoon there will be a joint meeting with the Social Hygiene League. The subject for discussion will be congenital syphilis.

Wednesday afternoon the local committee is planning a motor trip to be followed by a tea at Glen Lake Sanatorium as the guests of Dr. Ernest S. Mariette, superintendent, and Marguerite Ridler, director of social work.

Miss Cannon to Speak at Luncheon

The recently appointed joint committee of the National Tuberculosis Association and the American Association of Hospital Social Workers has arranged a luncheon meeting on Thursday, June 18. Ida M. Cannon, director of social service, Massachusetts General Hospital, Boston, will speak on the subject: "The Place of the Social Worker in the Tuberculosis Program." This meeting will be followed by six small discussion groups which have been planned in response to requests for round table consideration of the subjects. Each will be conducted by an able leader. Discussion will be informal and free. The subjects will be: "Cooperative Practice in Medical Social Work and Public Health Nursing"; "The Use of the Hamilton Terminology in Medical Social Case Work"; "Methods of Statistical Recording in Medical Social Work"; "The Development of Resources to Aid in Medical Social Planning for Patients From Rural and Unorganized Communities"; "Social Information in the Medical History"; "The Social Worker and Hospital Administration."

On Thursday evening medical social workers will have an opportunity to hear some of the results of the medical section of the White House Conference on Child Health and Protection. Ida M. Cannon, chairman, subcommittee on medical social service of Committee C, medical care for children, and Dr. Henry F. Helmholz, professor of pediatrics, University of Minnesota graduate school of medicine and a member of Committee A, growth and development, will be the speakers at a dinner meeting.

The association is conducting its case competition again this year. On Friday afternoon, June 19, the committee conducting the competition will report the results and discuss the case receiving first place and other facts of interest in this stimulating program.

The woman's auxiliary of the Hennepin County Medical Society will give a tea for the medical social workers following this meeting. Visits to the hospitals and institutions in Minneapolis, St. Paul and Rochester, will be arranged.

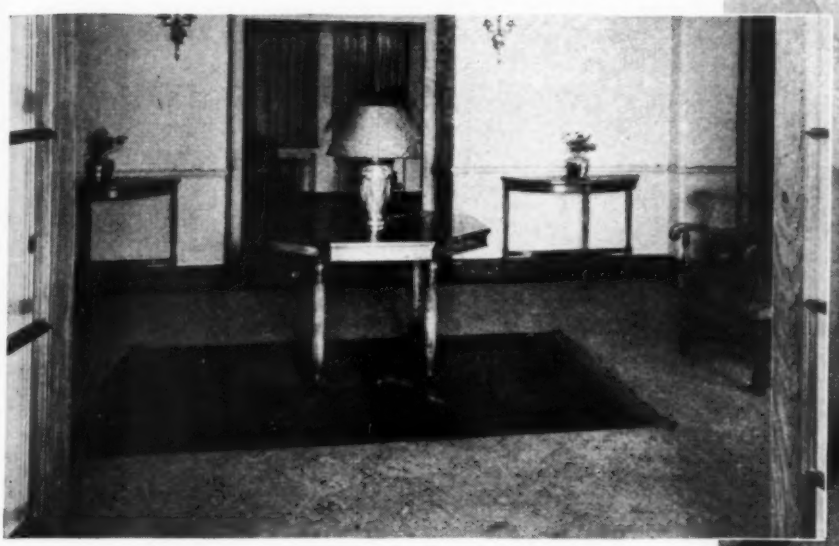
Delegates going to the meeting, are cordially invited by the Illinois district to stop in Chicago. Ruth Painter Curtiss, St. Luke's Hospital, Chicago, will make arrangements for visits to hospitals and clinics of the city. Hotel reservations should be made with C. H. Chadbourn, chairman, committee on hotels and housing, Hotel Vendome, 21 South Fourth Street, Minneapolis.

A New Significance for Mother's Day

That from henceforth Mother's Day will hold a new significance for American citizens is the hope of the Maternity Center Association which has chosen the coming Mother's Day, May 10, as the date to begin an attempt for adequate maternity care for every mother in this land. The association is waging a campaign to direct the attention of the country to America's deplorable maternal death rate, the highest in any civilized country.

The association is planning a widespread publicity campaign. It will supply every newspaper and magazine in the country of every type of interest with pictures, stories, editorial comment and articles for use on Mother's Day. Plans for radio talks have been made from coast to coast, to be given by physicians as well as laymen. Meetings of women's clubs are to conduct special programs designed to show what can be done to stop the waste in mothers' lives.

IN RUBBER



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Corridor and Entrance, Lankenau Hospital, Philadelphia — laid with Goodyear Rubber Flooring — Thomas, Martin, and Kirkpatrick, Architects — flooring by Selby, Battersby & Co., Phila.

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CHECK over in your mind the demands which hospital floors must meet. You want cleanliness—strict and continuous. You want silence. You want ease of maintenance, durability, and beauty in full accord with the plan and color scheme of your buildings.

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The resilient structure of rubber toughly resists wear. It is easy underfoot. It muffles the click of heels in corridors. The colors of Rubber Flooring, as made by Goodyear, are permanent and fully sufficient for any decorative need.

Ask your architect about this most modern flooring. The new low prices for Goodyear Rubber Flooring make the present a good time to install it in new structures or in buildings now in use. Write to Goodyear, Akron, Ohio, or Los Angeles, California, for complete information.

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NEWS OF THE MONTH (Cont'd)

Coming Meetings

American Association of Hospital Social Workers.
President, Edith M. Baker, Washington University Dispensary and Allied Hospitals, St. Louis.
Executive Secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Minneapolis, Minn., June 14.

American College of Surgeons.
President, Dr. C. Jeff Miller, New Orleans.
Director general, Dr. F. H. Martin, Chicago.
Next meeting, New York City, October 12-15.

American Dietetic Association.
President, S. Margaret Gillam, University Hospital, Ann Arbor, Mich.
Business Manager, Dorothy I. Lenfest, 25 East Washington Street, Chicago.
Next meeting, Cincinnati, Ohio, October 19-21.

American Hospital Association.
President, Dr. L. A. Sexton, Hartford Hospital, Hartford, Conn.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Toronto, September 28 to October 2.

American Protestant Hospital Association.
President, Dr. B. A. Wilkes, Hollywood Hospital, Hollywood, Calif.
Executive secretary, Frank C. English, D.D., Hyde Park, Station O., Cincinnati.
Next meeting, Toronto, September 25-28.

American Public Health Association.
President, Dr. Hugh S. Cumming, Washington, D. C.
Next meeting, Montreal, September 14-17.

Catholic Hospital Association of the U. S. and Canada.
President, Alphonse M. Schwitalla, S.J., St. Louis University School of Medicine, St. Louis.
Secretary-treasurer, Sister Mary Irene, St. Mary's Hospital, St. Louis.
Next meeting, St. Paul, Minn., June 16-19.

Colorado Hospital Association.
President, Dr. Maurice H. Rees, University of Colorado School of Medicine and Hospitals, Denver.
Executive Secretary, Frank J. Walter, St. Luke's Hospital, Denver.
Next meeting, Greeley, June 26.

Connecticut Hospital Association.
President, Dr. B. Henry Mason, Waterbury Hospital, Waterbury.
Secretary, Maud E. Traver, New Britain Hospital, New Britain.
Next meeting, Danbury, May 6.

Florida Hospital Association.
President, J. A. Bowman, Munroe Memorial Hospital, Ocala.
Executive Secretary, Fred M. Walker, Duval County Hospital, Jacksonville.
Next meeting, Orlando, May 12-13.

Hospital Association of the State of Illinois.
President, E. E. Sanders, Ravenswood Hospital, Chicago.
Secretary, E. I. Erickson, Augustana Hospital, Chicago.
Next meeting, Chicago, May 13-15.

Indiana Hospital Association.
President, Dr. William A. Doeppers, Indianapolis City Hospital, Indianapolis.
Secretary, Gladys Brandt, Cass County Hospital, Logansport.
Next meeting, Chicago, May 13-15.

International Hospital Congress.
Secretary general, Dr. E. H. Lewinski Corwin, 2 East 103rd St., New York City.
Next meeting, Vienna, June 8-14.

Kentucky Hospital Association.
President, Dr. John R. Wathen, St. Anthony's Hospital, Louisville.
Secretary, Agnes O'Roke, Kosair Crippled Children's Hospital, Louisville.
Next meeting, Louisville, May 4-5.

Michigan State Hospital Association.
President, Sidney G. Davidson, Butterworth Hospital, Grand Rapids.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Next meeting, Saginaw, May 20-21.

Minnesota Hospital Association.
President, Paul H. Fesler, University Hospital, Minneapolis.
Secretary-treasurer, James McNee, St. Luke's Hospital, Duluth.
Next meeting, Duluth, June 22, and Lutsen, June 23-24.

National League of Nursing Education.
President, Elizabeth C. Burgess, Teachers College, Columbia University, New York City.
Executive secretary, Nina D. Gage, 370 Seventh Ave., New York City.
Next meeting, Atlanta, Ga., May 4-9.

New Jersey Hospital Association.
President, Dr. Earl H. Snavely, Newark City Hospital, Newark.
Executive secretary, Charles F. Dwyer, Newark City Hospital, Newark.
Next meeting, Atlantic City, May 7-8.

Hospital Association of the State of New York.
President, Sheldon L. Butler, Long Island College Hospital, Brooklyn.
Secretary, Boris Fingerhood, United Israel-Zion Hospital, Brooklyn.
Next meeting, Syracuse, May 8-9.

North Carolina Hospital Association.
President, Dr. L. V. Grady, Carolina General Hospital, Wilson.
Secretary, Edwin G. Farmer, Carolina General Hospital, Wilson.
Joint meeting with South Carolina and Virginia Hospital Associations, Durham, May 19-21.

South Dakota State Hospital Association.
President, Dr. Robert D. Westaby, New Madison Hospital, Madison.
Secretary, C. W. Carlson, Moe Hospital, Sioux Falls.
Next meeting, Madison, June 9-10.

Wisconsin Hospital Association.
President, Dr. R. C. Buerki, State of Wisconsin General Hospital, Madison.
Secretary, L. C. Austin, Mt. Sinai Hospital, Milwaukee.
Next meeting, Chicago, May 13-15.

The Greatest Improvement Ever Made in Drainage Tubing

IMMEDIATELY after the first Matex gloves were sold through surgical supply dealers, we received hundreds of requests from Hospital Superintendents and Surgeons, asking that other surgical rubber products be made from Matex, the long-life, non-ageing, tough and extremely thin rubber.

And now, in compliance to these requests, we announce three new products made of Matex.

MATEX SURGICAL DRAINAGE TUBING

Packed in 18 inch lengths, one dozen to the box at $2.25 per dozen. Made in seven sizes, 5/16, 3/8, 1/2, 5/8, 3/4, 7/8 and 1 inch diameters.

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21 inches long. Made only in sizes 7, 7½, 8 and 8½. Sold at your supply house at $2.25 per pair.

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Made with one or two fingers, with shield. $4.50 per dozen.

Matex offers the surgeon an entirely new conception of secureness and dependability. Hospital and laboratory tests have proved that Matex will out-last four times the average brown milled gloves or examination cots used in the past and Matex Surgical Drainage Tubing by reason of this toughness, strength and non-ageing quality, is a positive assurance of unequalled dependability.

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THE MATEX TEST OFFER

We claim that Matex Gloves, Cots and Surgical Drainage Tubing are stronger, tougher and will last longer than brown-milled products. And being far thinner than brown-milled gloves they allow the most natural sensitivity of the fingers.

Write today and a free sample will be mailed for your use. Test it. After fifteen successive sterilizations Matex will have a higher tensile strength than the old fashioned brown-milled gloves after its first autoclaving.

ANODE MATEX PRODUCT

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SURGEONS' GLOVES

THERE IS ONLY ONE MATEX

NEWS OF THE MONTH (Cont'd)

Illinois, Indiana, Wisconsin Ready for Joint Convention

CAREFULLY planned in every detail is the program of the Illinois-Indiana-Wisconsin Hospital Associations to be held in Chicago, May 13, 14 and 15. The first day is to be devoted to the hospital problems peculiar to each state. The last two days, the associations will meet jointly for a consideration of general problems.

Appearing on the program of the Indiana association the first day are: Dr. William A. Doeppers, superintendent, Indianapolis City Hospital, and president, Indiana Hospital Association; the Rev. J. H. Baurenfiend, superintendent, Evangelical Hospital, Chicago; George W. Wolf, business manager, Home Hospital, Lafayette, Ind.; Edward Rowlands, assistant administrator, Indiana University Hospitals, Indianapolis; Gladys Brandt, superintendent, Cass County Hospital, Logansport, Ind.; Edward T. Thompson, administrator, Indiana University Hospitals, Indianapolis.

Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, and president, Wisconsin State Hospital Association, will preside at the Wisconsin meeting which will consist of a round table conference.

E. E. Sanders, superintendent, Ravenswood Hospital, Chicago, and president, Hospital Association of the State of Illinois, will preside at the Illinois meeting.

The first joint session will be held on the second day, with E. E. Sanders presiding. Appearing on the program are: John A. McNamara, executive editor, THE MODERN HOSPITAL; E. I. Erickson, superintendent, Augustana Hospital, Chicago; the Rev. Herman L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee; Charles Wordell, manager, St. Luke's Hospital, Chicago; Albert G. Hahn, business manager, Deaconess Hospital, Evansville, Ind.; L. G. VonderHeidt, superintendent, West Suburban Hospital, Oak Park, Ill.; Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, will be the featured speaker at the joint luncheon. Doctor Doeppers will preside. Others who will speak briefly are J. Dewey Lutes, superintendent, Lakeview Hospital, Chicago, and L. C. Austin, superintendent, Mt. Sinai Hospital, Milwaukee.

A report of the financial losses to hospitals of Illinois, Indiana and Wisconsin through automobile accidents in 1930, which will be made by Matthew O. Foley, editor, *Hospital Management*, will head the afternoon program. Other important subjects to be discussed at this session will include "The Right of the Governing Body of the Hospital to Determine Staff Membership," by Thomas V. McDavitt, bureau of legal medicine and legislation, American Medical Association; "Insuring a Competence for Faithful Hospital Workers," by G. Powell Hamilton, Equitable Life Assurance Company, New York City. These papers are to be discussed, respectively, by Howard E. Hodge, superintendent, Decatur and Macon County Hospital, Decatur, Ill., Dr. Bert W. Caldwell and Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., and president, American Hospital Association.

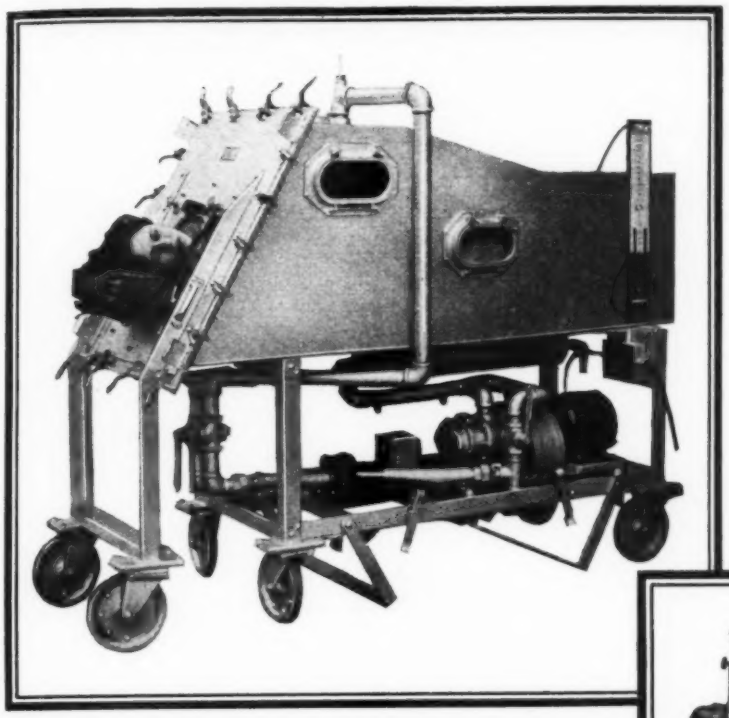
Mr. Fesler to Be Toastmaster

The annual banquet will be held in the evening with Paul H. Fesler, superintendent, University Hospitals, Minneapolis, and president-elect, American Hospital Association, as toastmaster. The main address will be given by Dr. Lewis A. Sexton. Robert E. Neff, administrator, University Hospitals, Iowa City, will also give an address.

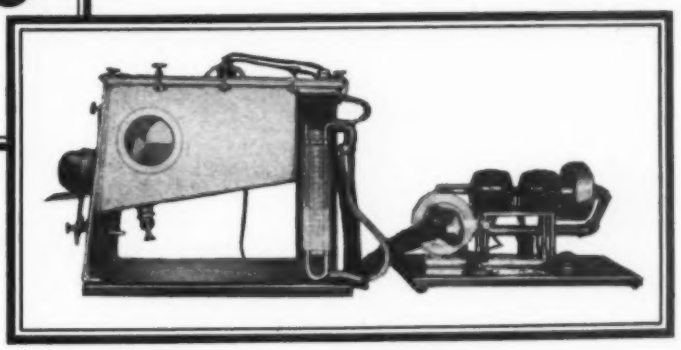
Buying and budgeting will be the general theme of the morning program of the third-day session, with the following speakers: John G. Dinsmore, superintendent, University of Chicago Clinics, Chicago; Ralph M. Hueston, superintendent, Silver Cross Hospital, Joliet, Ill.; Alford R. Hazzard, superintendent, Easton Hospital, Easton, Pa.; Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill.; L. C. Austin, superintend-

(*Continued on page 144*)

The DRINKER RESPIRATOR—for the PROLONGED administration of ARTIFICIAL RESPIRATION



In cases of infantile and diphtheritic paralysis, gas and drug poisoning, electric shock and drowning. An infant model is made for the resuscitation of newborns and prematures.



A PREPROVED DEVICE FOR ARTIFICIAL RESPIRATION

Both the Adult and Infant Respirators are built on a simple scientific principle which so closely approximates normal respirations that patients may be treated for weeks without physical discomfort, or injury to the respiratory system.

The Drinker Respirator consists of a steel chamber which encloses the patient's body except the head which protrudes through a soft comfortable rubber collar. By means of an electrically driven pump and valve mechanism the patient's chest and diaphragm are alternately exposed to a reduced air pressure which causes inhalation, and then to a normal pressure which causes exhalation.

Both the rate and depth of respiration are under control at all times. Patients may sleep, eat, drink and receive medical treatment while in the respirator. This apparatus has run from 71 to 96 days continuously and successfully.

The value of the Drinker Respirator is widely recognized and it is the consensus of opinion that their strategic distribution in hospitals throughout the country is very desirable.

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Hospital .....

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PERSONALS

DR. WALTER C. G. KIRCHNER, St. Louis, was recently appointed medical director of the City Hospital of that city.

DR. GEORGE A. MACINTOSH is the newly appointed superintendent of Victoria General Hospital, Halifax, Nova Scotia, succeeding W. W. KENNEY, who died recently.

DR. J. C. NIELSON, assistant superintendent, Norfolk State Hospital, Norfolk, Neb., has recently assumed charge of the hospital, succeeding DR. GEORGE E. CHARLTON.

WALTER E. GOLLINGS, Decatur, Ill., is the new superintendent of the Wabash Employees Hospital Association, succeeding M. J. FOHEY, Detroit, who was elected to serve the remainder of the fiscal year following the death of J. E. CRIM.

DR. W. M. LYNCH, superintendent, Farview Hospital for Criminal Insane, Scranton, Pa., died recently following a long illness.

EDNA H. HOWARD, assistant superintendent of hospitals, Cambridge, Md., will succeed ELSIE K. GRAHAM as superintendent of the Lynchburg Hospital, Lynchburg, Va.

MABEL HENRY is the newly appointed superintendent of Graham Hospital, Keokuk, Iowa.

THELMA WODETZKI has recently been named superintendent, Jarman Memorial Hospital, Tuscola, Ill.

MARION PETERSON, formerly administrative dietitian, Lakeside Hospital, Cleveland, has been appointed administrative dietitian, Jewish Hospital, Cincinnati.

DR. CARLISLE S. LENTZ has resigned as superintendent, University Hospital, Augusta, Ga., to accept the superintendency of the University of Virginia Hospital, Charlottesville, Va. DOCTOR LENTZ will also serve as professor of hospital administration in the department of medicine, University of Virginia. His resignation is effective June 30.

WILLIAM H. FRERSING, business man and public accountant, has been appointed superintendent and financial secretary of the Deaconess Hospital, Cincinnati. He succeeds the REV. A. G. LOHMANN, who will retire on his seventieth birthday anniversary, June 12.

EMMA ESHENBACH has been named assistant superintendent, Quakertown Community Hospital, Quakertown, Pa.

LUCY JOHNSON has been appointed superintendent of the new Lewis County General Hospital, Lowville, N. Y.

MIRIAM KEHLER has resigned as superintendent of the Van Wert County Hospital, Van Wert, Ohio.

ANNA KELLY succeeds RUTH J. REIF as superintendent of the Syracuse Memorial Hospital, Syracuse, N. Y.

MADELINE KENT has resigned as superintendent of the Sunlight Hospital, Scituate, Mass.

GEORGE T. MACBETH was recently elected president, board of managers, Mt. Vernon Hospital, Mt. Vernon, N. Y.

CHARLES SHERMAN is the newly elected president of the board, Lutheran Hospital, Omaha, Neb.

DR. JOHN H. SNOKE, since 1927 superintendent, Bryn Mawr Hospital, Bryn Mawr, Pa., has resigned.

JAMES P. CAHEN has retired as president, West Side Hospital, New York City, after a service of thirty-eight years. He has been made honorary chairman of the board of trustees.

CLEO S. ROGERS, anesthetist, Santa Barbara General Hospital, Santa Barbara, Calif., has been named superintendent, Santa Maria Hospital, Santa Maria, Calif., succeeding ANNIE FOSTER, resigned.

DR. THOMAS A. DEVAN will succeed DR. GEORGE H. STONE as superintendent of the East Maine General Hospital, Bangor.

PERSONALS

DR. C. E. SISSON has been appointed medical superintendent, San Diego County General Hospital, San Diego, Calif. DOCTOR SISSON has been superintendent of the State Hospital, Napa, Calif., for the last four years.

OLIVER GOODELL PRATT, superintendent, Salem Park Department, Salem, Mass., has been elected superintendent of the Salem Hospital, succeeding WILBUR B. BIGELOW, resigned.

DR. J. M. FERGUSON has been named medical head of the new United States Veterans' Hospital, Lexington, Ky. The hospital, which is almost completed, has a capacity of 250 beds.

THOMAS F. DAWKINS, New York City, has been appointed superintendent of the Physicians Hospital, Plattsburg, N. Y., succeeding DR. IRVING S. HAINES, resigned. Mr. DAWKINS has had a number of years of experience as a hospital administrator.

STEVE R. JOHNSTON, superintendent, Grady Hospital, Atlanta, Ga., and ASMON LEWIS, assistant superintendent, have resigned. MR. LEWIS' resignation is effective April 1, and MR. JOHNSTON'S July 1.

JAMES R. MAYS, New York City, has been appointed superintendent of the Elizabeth General Hospital and Dispensary, Elizabeth, N. J., for the purpose of reorganization and the preparation of plans for future expansion and development. MR. MAYS succeeds JOHN M. CRATTY as superintendent.

DR. WADE HAMPTON FROST has been appointed dean of the School of Hygiene and Public Health, Johns Hopkins University. He succeeds DR. WILLIAM H. HOWELL, director, who retires on July 1.

M. E. FOHEY, St. Louis, has been elected superintendent, Wabash Employees' Hospital Association, Decatur, Ill., succeeding the late J. E. CRIM, who had served the association since it was founded.

SISTER M. MODESTA has resigned as superintendent of St. Vincent's Hospital, Montclair, N. J., because of ill health. She has been succeeded by SISTER HELEN LOUISE. SISTER ANGELIQUE has been named assistant superintendent.

ESTHER T. JACKSON is the new superintendent of John McDonald Hospital, Monticello, Iowa.

DR. CHARLES D. CRANDALL has been named superintendent, Greenpoint Hospital, Brooklyn, N. Y.

JESSIE ERICSON is the superintendent of the new 100-bed Medical Arts Hospital, recently opened in Edinburg, Tex.

OLIVE M. MURPHY has recently become superintendent of the Randolph County Hospital, Winchester, Ind.

GRACE MORPHY HULST has resigned as assistant superintendent, Paul Kimball Hospital, Lakewood, N. J., to become obstetrical supervisor, Hackensack Hospital, Hackensack, N. J.

DR. EUGENE A. SCHARFF, former superintendent, City Hospital, St. Louis, has been elected superintendent of the new St. Louis County Hospital, which is expected to be opened within the next few months.

FERDINAND C. HILKER, superintendent of Lutheran Hospital of Manhattan, New York City, has assumed the superintendency of Ithaca Memorial Hospital, Ithaca, New York.

DR. WILLIAM H. CORSON has been appointed superintendent of the new Harborview Hospital, Seattle, Wash. DOCTOR CORSON is a pioneer Seattle physician.

DR. HILTON R. CARR has been named to succeed the late GEORGE B. STEWART as superintendent of the Shelby County Hospital, Memphis, Tenn. DOCTOR STEWART has been a practicing physician in Memphis for the last six years.

DR. LOUIS J. LISTA was recently appointed superintendent, Siskiyou County General Hospital, Yreka, Calif.

He Fights Plumbing Failure and High Costs

Faulty design, inferior construction or improper layout of plumbing in schools, hospitals, industrial plants, public buildings and similar places, can develop into serious menaces to health and efficiency.

For failure in such installation creates unsanitary conditions, pollution and disease germs.

But in addition, such failures represent a very tangible waste in dollars for repair and replacements, which often amount to terrifying figures.

It is the job of the Clow Soldier of Sanitation to make sure that each installation, on which he is called in, provides the very ultimate in sanitation surety—and also to make certain that the installation will function on a very minimum of dollars.

To back him in this important work, Clow goes to extreme lengths in the factory.

For example: every battery of urinals, closets, lavatories and similar fixtures is set up according to specifications before shipment—and tested under conditions bordering on actual service.

Such plumbing is not intended to fail, wear out rapidly or to be rejected after partial installation.

And builders, architects, owners and plumbers have the assurance of perfect sanitation, with the lowest possible cost, through the years.

On all jobs where sanitation may develop into an acute problem—the Clow Soldier of Sanitation will gladly give you the fruits of Clow's 52 years of experience. And this man has behind him the most complete line of specialized fixtures in the world. Call him in. This is Bill Abell, Aurora, Ill.—North Central Illinois Territory.

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NEWS OF THE MONTH (Cont'd)

Florence Nightingale Bibliography Is Compiled

Apropos of the celebration of the birthday of Florence Nightingale on May 12, the following bibliography has been compiled by the Hospital Library and Service Bureau, American Hospital Association, for those who may be planning programs for the occasion.

Adams, E. C. and Foster, W. D., Heroines of Modern Progress, 1922, Macmillan, New York City. (Character sketch p. 120-140) $1.50.

Aikens, Charlotte A.,[1] Lessons From the Life of Florence Nightingale, 1915, Lakeside Pub. Co., New York City, Paper, 40 cents.

Aldis, M.,[1] Florence Nightingale: An Appreciation, 1914, Nat'l Organ. for Pub. Health Nursing, New York City, Paper.

Andrews, Mrs. Mary R., Lost Commander—Florence Nightingale, 1929, Doubleday Doran & Co., Garden City, N. Y., $3.

Brainard, Annie M., Evolution of Public Health Nursing, 1922, Saunders, Philadelphia. (Florence Nightingale p. 85-101) $3.

Buehler, J. R. and Allison, S. B., Grace Darling and Florence Nightingale, A. Flanagan Co., Chicago, 10 cents.

Cock, Sir Ed. T.,[1] Life of Florence Nightingale, 1913, Macmillan, New York City, $7.50.

Cock, Sir Ed. T., Short Life of Florence Nightingale; With Additional Matter, 1925, Macmillan, New York City, $3.50.

Curtis, W. E.,[1] Around the Black Sea, 1911, Doran, New York City. (Florence Nightingale p. 313-324).

Dock, Lavinia L. and Stewart, Isabel M., Short History of Nursing, 1920, Putnam, New York City. (Florence Nightingale p. 117-141) $3.50.

Elliot, G., Florence Nightingale Tableaux, 1920, Macmillan Co., Paper, 30 cents.

Goodnow, Minnie, Outlines of Nursing History, 1923, Saunders, Philadelphia. (Florence Nightingale p. 63-92) $3.

Hall, Eleanor F., Florence Nightingale, 1920, Macmillan Co., New York City, $1.40.

Hallock, Grace T. and Turner, C. B.,[2] Health Heroes—Florence Nightingale, 1928, Metropolitan Life Insurance Company, New York City, Paper, free.

Holmes, Marion, Florence Nightingale: A Cameo Life Sketch, 1912, Women's Freedom League, London, England.

Is That Lamp Going Out? To the Heroic Memory of Florence Nightingale, 1911, Hodder, New York City.

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Mabie, H. W., Heroines That Every Child Should Know, 1915, Grosset, New York City, $1.

McFee, Mrs. Inez N., Story of Florence Nightingale, 1912, F. A. Owen Pub. Co., Dansville, N. Y., Paper, 15 cents.

McKenna, Stephen, While I Remember, 1921, Doran, New York City, $3.50.

Matheson, Annie,[1] Florence Nightingale; A Biography, 1914, T. Nelson & Sons, New York City, $1.25.

Pennock, Meta R., Makers of Nursing History, 1928, Lakeside Pub. Co., New York City. (Florence Nightingale p. 20-21) $1.50.

Pollard, Eliza F., Florence Nightingale, the Wounded Soldier's Friend, 1911, Partridge, London, England.

Quiller-Couch, Sir A. T., Roll Call of Honor; a New Book of Golden Deeds, 1913, T. Nelson & Sons, New York City, $2.50; Victors of Peace, 1928, T. Nelson & Sons, New York City, 60 cents.

Reid, E. G., Florence Nightingale, a Drama, 1922, Macmillan, New York City, $1.25.

Richards, Mrs. Laura E. (Howe), Florence Nightingale the Angel of the Crimea: A Story for Young People, 1909, Appleton, New York City, $1.75.

Strachey, G. Lytton, Eminent Victorians, 1918, Putnam, New York City, (Florence Nightingale p. 135-204) $3.50; Eminent Victorians, Garden City Pub. Co., Garden City, L. I., New York, $1.

Tooley, Mrs. Sarah A.,[1] Life of Florence Nightingale, 1917, Macmillan, New York City, $2.

Wakeford, Constance, Wounded Soldier's Friend, 1917, Headley, London, England. (Florence Nightingale p. 132).

Wentle, W. J.,[1] Story of Florence Nightingale, Whittaker, New York City.

Worcester, Alfred, Nurses and Nursing, 1927, Harvard University Press, Cambridge, Mass. (Florence Nightingale p. 50-76) $2.

[1]Out of print and may be bought through second-hand dealers.

[2]The Metropolitan Life Insurance Company, New York City, will furnish a film, "Life of Florence Nightingale," free to hospitals and schools of nursing, with booklets, "Health Heroes," for general distribution.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

The Consulting Dietitian and Her Value to the Hospital

By FAIRFAX T. PROUDFIT
School of Nursing, University of Tennessee, Memphis

EVERY worth while profession calls for sacrifice on the part of its followers, and a new profession such as dietetics is tried in the fire of criticism and ridicule and stands or falls according to its worth and its importance to humanity.

The dietitian to-day does not have to prove that her presence is needed in the hospital. She is considered as much a part of the organization as any other staff member. To be sure, she knows that if she does not succeed she will be replaced by a dietitian who is capable of succeeding.

The consulting dietitian, then, is simply the dietitian who has given unsparingly of her time and strength in the study of her subject, has faced problems and discouragements and has overcome the obstacles that beset her.

Dietetics is a broad subject. It requires not only a fundamental knowledge of nutrition and diet therapy but a breadth of understanding that only research and practical experience can give. Thus years of study, observation and practice go into the making of a consultant, no matter which branch of the subject she may select as her own particular field of work.

There are three outstanding branches of dietetics in which the services of a consulting dietitian are of value: (1) nutrition and diet therapy; (2) the construction and equipment of the department; the handling of the personnel and research (chiefly in food problems or in the use of definite foods); (3) food itself, including menu planning and recipes.

The dietitian who is capable of giving constructive advice upon the building and equipment of a model dietary department, including its proper location, ventilation, lighting and accessibility, is an invaluable assistant not only to the institutional boards and managers but to the architect as well, since a department that has been properly constructed and organized in the beginning requires less effort and probably less money to run than one that must frequently be changed to meet the needs of the institution and of its various personnel.

Consultant Can Save the Hospital's Money

The consultant who is occupied with solving food problems for large manufacturing firms and who personally undertakes the trying out of different pieces of equipment to determine their efficiency for institutional use, or one who has had a wide experience in the use of many types of stoves, conveyors, steam tables and other equipment is capable of speaking with authority upon their value. Her advice in many instances can save a hospital many thousands of dollars.

It is the manufacturer's aim to meet the needs and desires of his public, but he does not always understand what these needs and desires are. For example, he may offer a machine that theoretically at least meets every requirement. But there are innumerable instances in which a piece of equipment has been tried and abandoned simply because there was lacking that vital something necessary to make it indispensable in the kitchen.

The work of the consultant in nutrition and diet therapy is in many ways identical with the work done in the hospital and in the school except that

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GORHAM hospital ware is attractive . . . practical . . . economical. The lines of Gorham hospital ware are purposely kept simple . . . This insures economy in servicing.

The metal of which all Gorham hospital ware is made is nickel silver, heavily silver plated—it withstands years of hard usage—and insures low replacement cost.

On the tray: In the center front is a COMBINATION BOWL which has many different uses: to hold orange-juice glass; without the insert, to serve fruit; for cereals or soups, sea food or fruit cocktails, ices, etc.

Directly behind the COMBINATION BOWL is the Gorham special, easily filled HOT WATER PLATE with special cover.

The COFFEE POT can be had with goose-neck spout or as illustrated. The accompanying CREAM PITCHER and SUGAR BOWL are low, hard to tip over.

Note the special VEGETABLE DISH with cover—exceptionally good for keeping things hot. The ICE CREAM STAND and the remaining articles—SALT AND PEPPER SHAKERS, BUTTER PAT, NAPKIN RING, and the FLATWARE are typical of Gorham quality.

No soft metal or soft solder is used in the construction of Gorham hospital silverware.

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the consultant is not attached to a single institution. She may be consultant to half a dozen clinics and may practice outside these clinics also. Indeed, in many instances the bulk of her practice is made up of out of town patients, sent in by the doctors in surrounding towns for dietary adjustments.

The dietitian is entitled to be called a consultant when she has arrived at that place in her career when she is considered capable of offering constructive criticism and advice to others who may not have had the experience or training to accomplish this work or to solve these problems for themselves.

To Be Healthy, Eat the Right Foods

The problems in normal nutrition are chiefly of a preventive character. It is the aim of every consultant in nutrition and diet therapy to do as much preventive work as possible. This is an age of prevention rather than of cure, and in order to prevent disease she must advocate and teach methods of prophylaxis.

No preventive measure is more far-reaching in its effect than the teaching of good food habits. The nutritionist is sometimes called upon to suggest ways and means of conveying the idea not only to the children but to their parents as well. She is frequently called upon to organize the diet work in prenatal clinics and to follow up the work by visiting the mothers' classes held by parent-teachers' associations. This work could be accomplished by the dietitian in charge of the school lunch room provided she had had the essential contact with the prenatal work done in the city and the time necessary to undertake the additional work. As a rule she has not had these contacts. In many instances her efforts have been so closely confined to the problems pertaining to her own job that she has not had the opportunity to look further afield or to study the work, which is different from but closely allied to her own.

The mothers, too, are likely to consult the family physician regarding Johnny's lack of gain in weight or Willie's poor teeth, and for a private case the physician calls upon the consulting dietitian, whom he believes to be capable of handling the situation correctly and tactfully, rather than upon the school dietitian.

The consultant is often asked to solve the financial or economic problems that are in a way responsible for certain failures that have occurred in the dietary management of some member of the family whom the doctor has placed upon a diet. These cases are not infrequent, but they are nevertheless distressing. To find one member of a family group being kept alive at the expense of the health of all of its other members is not right and in the majority of instances is not necessary. With a careful adjustment of the family menu, the dietary requirements of the sick one can be adequately met without materially interfering with the family budget. To be sure, this requires careful planning and an intensive study of the individual case as well as of the financial status of the family group.

Few cases require such totally different food materials that the comfort of all the members of the family must be sacrificed in order to meet the special requirements of one. Consider, for example, the diabetic. It is not only possible but desirable in planning his menus to make use of as many of the dishes prepared for the group as possible rather than to set him aside as the one to receive all the consideration, allowing the rest to get along as best they can. Such an arrangement is bad for the family and equally so for the diabetic patient. Not only does it foster selfish disregard for the comfort of others but it centers his entire attention upon himself to such an extent that he is never allowed to forget his condition. Such treatment is unwise from a psychologic standpoint and adds nothing to his or to anyone's happiness.

The same theory holds good in other conditions. The consultant endeavors to provide the connecting link between the patient and the physician and also between the physician and the housewife or the one who is placed in charge of the special diet in the home. She has an opportunity to see the inner workings of the household machinery and is thereby better able to suggest means for solving some of the intricate problems that have in all probability interfered with the carrying out of the diet.

The consultant is thus made the physician's coworker, undertaking that part of the treatment for which her training and experience have fitted her. In this respect she works with both the sick and the well.

How the Dietitian Can Help the Doctor

The highly specialized knowledge of diet therapy possessed by the dietitian is of inestimable value to the physician in his treatment of many diseases, not only those of a metabolic character but those of organic and functional types as well.

It is no longer considered wise to estimate a diet solely from a standpoint of energy value or of protein, carbohydrate and fat content. To-day the mineral and vitamin value of a menu plays an important part in its use in certain cases, and the uniformity of its cellulose content and its consistency must be considered if it is to produce the desired results.

You know that you're getting full pack— of the finest pineapple ever grown!

Spring Salad

Place Libby's Sliced Pineapple on crisp lettuce. Spread with softened nippy cheese. Cover with slice of tomato. Force dressing through pastry tube, and garnish with green pepper and parsley.

Pineapple Tapioca, Libby

Cook tapioca in juice from Libby's Crushed Pineapple, over hot water until transparent. Place Crushed Pineapple in baking dish. Add dots of butter and the tapioca. Sprinkle with sugar, and bake in oven. Serve with cream.

6 different sizes for every hospital service

SIZE CAN	SLICED	TIDBITS	CRUSHED
No. 10	6 lb. 10 oz. 29 #2½ slices, *or* 40 #2 slices, *or* 50 #2 thinner slices	6 lb. 10 oz.	6 lb. 10 oz.
No. 2½ tall	1 lb. 14 oz. 8 slices	1 lb. 14 oz.	1 lb. 14 oz.
No. 2 tall	1 lb. 4 oz. 8 slices	1 lb. 4 oz.	1 lb. 4 oz.
No. 1 tall	14 oz. 8 slices	14 oz.	14 oz.
No. 1 flat	9 oz. 4 slices	9 oz.	9 oz.
8 oz.		8 oz.	8 oz.

Libby's Pineapple from our own Hawaiian plantations

IN hospital diets, few fruits are as thoroughly valuable as pineapple!

A rich source of fruit sugar, mineral salts, the A, B and C vitamins—pineapple is widely recommended by dietetic authorities. For its effect is simple, direct, entirely beneficial and wholesome.

But it has these qualities in the highest degree only when it's been ripened on the plant, and packed right at the moment of mature perfection!

Now Libby brings you the finest pineapple ever grown! New, flawless fruit, the choice of an Hawaiian crop we've been developing for 20 years!

Packed as soon as it's cut, this Libby Pineapple has a sweet spiciness all its own—and the essential healthful properties.

When you buy it, you always know that you're getting full pack. Every can, in every one of the three styles, is perfectly uniform!

Order Libby's new Hawaiian Pineapple from your usual source, today. And have it on hand to serve in many different, economical ways—among them, the three shown here!

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Pineapple Circles

Simmer Libby's Sliced Pineapple in own juice, with sugar added, until soft. Roll puff paste ¼ inch thick. Cut in circles, size of Pineapple. Bake. Place Pineapple on crust. Serve with whipped cream and Maraschino cherries.

A dietitian who has reached the position of consultant assuredly understands these points. She is sufficiently familiar not only with the raw products that make up the daily ration but with the finished product and its behavior under the action of heat or cold, acid or alkali. She likewise knows the amount of fiber it contains and whether the cellulose is in a fine or a coarse state. She understands the value of substitution, not only for the sake of overcoming monotony but from a standpoint of economy, since it is obvious that a diet made up of expensive items, such as heavy cream and tenderloin steak, would be totally out of the question for patients who must count every penny.

Her work may involve the question of racial or religious habits or scruples. It is all very well to plan a diet program but it is a different matter to have it carried out. If the patient is an orthodox Jew, for example, it would be distinctly offensive to him if the dietary laws by which his life is governed were not considered. These laws must be understood by the dietitian. Frequently the doctor does not know all of the foods that go into the making of a certain dish, hence when he orders it, unless the consultant understands the art of substitution and can assure the patient that she has omitted the prohibited combinations, the dish will be returned uneaten and the physician's orders will not have been carried out. That these matters can be satisfactorily adjusted has been proved again and again, but it is through her years of experience in the hospital that the dietitian has been able to recognize the food habits of various races, and through her study of the fundamentals of nutrition and diet therapy that she is able to carry out the diet program satisfactorily.

In like manner the consultant is able to detect a true idiosyncrasy against a food from a false one, and frequently makes it possible for the physician to carry out a definite line of procedure which if left to the decision of the patient would be entirely out of the question.

Fitting the Diet to the Patient

At first glance these points may seem unimportant, but as a matter of fact they constitute the chief difference between the experienced and the inexperienced, the successful and the unsuccessful, dietitian. The knowledge is not to be gained in a day but develops as a result of continuous observation of a large number of patients coming from all walks of life. It is her ability to fit the diet to the patient or the patient to the diet that has made the consultant in nutrition and diet therapy of real service to the physician and to humanity.

Among the abnormal conditions for which the consultant's services are considered most valuable are diabetes (especially juvenile diabetes and that variety complicated by other pathologic conditions), pernicious anemia, kidney and cardiac disturbances, hypertension, obesity and deficiency diseases. These conditions are ever before her, consequently she has an opportunity to learn much about them. When the condition is more obscure, she works with the doctor to find the trouble and perhaps suggests a scheme of diet whereby the patient may be made more comfortable.

It is not always the most complicated case that taxes most severely the skill and ability of the consultant, it is rather the long-drawn-out case which requires a continuous changing of the menu in order that the patient may be willing to stick to the diet ordered. This is as important as the formulating of the original prescription, since the carrying out of the diet may mean life or death to the patient.

Why the Doctor Needs the Consultant

If the physician could be sure that his diet orders would be carried out indefinitely, his responsibility would not be so great and possibly the consulting dietitian would not have come into being. However, the physician cannot be sure of this in the majority of cases. As long as the patient is very ill, his orders in regard to diet are likely to be followed, but when the acute danger seems to be over, it is human nature to relax, and to break the dietary rules becomes increasingly easy. The physician knows this common weakness and is now availing himself of the services of a consultant whose business it is to devise ways and means to accomplish the end without the patient's becoming restless during the process.

The training and experience that have gone into the development of the consultant in this field frequently enable her to put her finger upon some social or psychologic factor in the case which, under ordinary circumstances, might readily escape the notice of the physician. Hence it is not alone her knowledge of nutrition and diet therapy that makes of her a consultant but the combination of training and experience, which sharpens her perceptions and trains her judgment.

A discussion of the work of the consultant in nutrition and diet therapy would be incomplete without some mention of the obstacles that in many instances serve to block her path. She must realize that in the beginning she is a more or less unknown quantity. Of course, she must prove her ability, but she must go still further—she must prove to the physician that her services are indispensable to him as well as to his patients. She can undoubtedly relieve him of many of the burdensome details that go to make up the sum of prac-

REAL COFFEE

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THE neural patient who dislikes to give up the cheering warmth of coffee has been a problem for the physician in the past. To give up coffee wholly often meant a weakening of morale. To keep on drinking coffee meant disturbed sleep and a bad effect on the nerves.

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And the blend is improved and better . . . delicious, satisfying . . . as only a coffee of the finest South American grade can be. New processes, developed in the Battle Creek plant, have greatly improved the flavor of Kaffee Hag Coffee. Only the finest coffee beans in the world are used—blended to make a beverage that delights the most critical coffee lover.

Recommend Kellogg's Kaffee Hag Coffee to your patients. Tell them here is a coffee that they can drink—without fear of unwelcome results.

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Kaffee Hag Coffee is accepted by the Committee on Foods of the American Medical Association. It is often recommended by physicians.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

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Not a substitute—but REAL COFFEE—*that lets you sleep*

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Another health product in which you will be interested is Kellogg's ALL-BRAN. It is pure bran with just enough of the famous Kellogg flavor added to make it a most appetizing and delicious cereal. ALL-BRAN promotes proper peristaltic action. Eaten daily it provides the bulk necessary for regular elimination.

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Please send me, free, a ½-lb. can of Kaffee Hag Coffee.
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tically all of the diet problems confronting the internist to-day.

It is almost impossible for the dietitian to make herself known to the medical profession unless she has served a long and successful term in a hospital where the medical staff has been in a position to observe and to evaluate her services or unless her name has become well known through her written work in important journals. Such recognition is essential to the building up of a consultation practice in nutrition and diet therapy. In other branches of the subject she will possibly have had to make use of other avenues of approach. The chief problem is to gain recognition in order that she may have an opportunity for showing what she is capable of doing in the way of dietary adjustment for problem cases or in problems of organization.

The financial factor, too, is no small one. The average salary of the hospital dietitian cannot be considered large. The amount she has been able to save and to invest is frequently too small to cover her overhead expenses over an extended period, consequently she must supplement her consulting practice with other work, which too often requires the major portion of her time and strength.

I shall not even attempt to enumerate the steps that are considered advisable or even essential in the attainment of success in the rôle of consultant in nutrition and diet therapy or in any of the other branches of dietetics that offer opportunities for the ambitious dietitian. It is apparent, however, to all who have given the subject much thought that the consultant is not made in a day but is the result of that slow but sure growth that is manifested only when the real need for her services develops. Given the opportunity for service by the medical and hospital authorities, the consultant in this important field stands an excellent chance of being as permanent a figure in the medical world as a consultant in any of the older and better known branches of medicine.[1]

The Relation of the Dietitian to the Purchasing Agent

There are two systems in vogue in the average hospital by which food supplies are obtained. In one, the dietitian builds her menu for the week and consults with the purchasing agent as to the current price of the ingredients necessary to this menu. She then requisitions the quantity of each article she requires and the purchasing agent does the actual buying.

[1]Read before the dietetic section at the annual meeting of the American Hospital Association, New Orleans.

Under the second system the dietitian not only decides upon the supplies she needs, but she also purchases them. It may be said that this system has much to recommend it. By this plan any possibility of the occurrence of misunderstandings between the dietitian and the purchasing agent is obviated and lost motion is prevented. When a dietitian is blessed with a buying sense, this is perhaps the method of choice in most hospitals.

On the other hand, in institutions of 200 or more beds, the dietitian must often choose between neglecting duties that demand her attention in the hospital, and spending half a day twice a week at the markets. Not only is it physically impossible in institutions of this size for the dietitian to perform these two types of work effectively, but frequently it is not fair to require her thus to perform two such major services. When the dietitian is expected to do the buying, she frequently is not able personally to visit the market, and must purchase by telephone, or only after a visit from one or more salesmen. True it is that she may receive a day or two in advance, competitive quotations on the various articles required, but paper buying is not as effective as a method by which goods are inspected first hand.

How to Avoid Friction

When the former system is in use, there is a strong possibility of friction arising between the dietitian and the purchasing agent, unless a definite working understanding has been reached between them. Once the weekly menu has been agreed upon, the purchasing agent should have no authority to alter in any way, without the consent of the dietitian, the type and quantity of the goods requisitioned. He must be analogous in his powers and prerogatives to a paying teller in a bank who without question cashes all checks, provided there is a sufficient balance on hand to the credit of the signer of the check.

The successful working out of this type of relationship depends entirely upon the dietitian's being fully informed as to the amount of her budget, and as to the amount of money that is being daily or weekly spent from it for food. The purchasing agent should not concern himself with the type of articles that the dietitian places on her menu, unless he observes a tendency on her part to exceed the amount of money allowed. When this is the case, he should call the matter to the attention of the dietitian or to his superior, the superintendent of the hospital. A well worked out understanding between the dietitian and the purchasing agent, and a careful observance of the details of this agreement, should prevent friction and should favor efficiency in buying.

OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D.
Director for Medical Services, Julius Rosenwald Fund, Chicago

More and Better Health Centers—Poland's Record of Progress

THE creation of health centers in Poland goes back to 1925, when the Rockefeller Foundation as a part of its public health program assisted the general department of health in Poland in the organization of the first model sanitary districts (health demonstrations) on the American plan. Little by little, the sanitary departments were coordinated into special clinics and health centers. "Thus," says Doctor Kacprzak, "from the union of two ideas—dispensary and demonstration—a single form of organization was born, presenting characteristics peculiar to Poland." [1] Here the "health center" has become an institution, combining the activities of a public health service with a preponderance of preventive medicine. To begin with, an urban district, from Mokotow to Warsaw, was chosen. Another was chosen in the neighborhood of Warsaw, the population of which was part suburban and part rural. Others were the rural district of Skierniewice and the purely industrial (coal mining) district of Bendzin. The responsibility for these four sanitary districts was given to physician-hygienists who had studied in some of the health schools of the United States or in those countries in Europe where social hygiene institutions were most thoroughly developed.

Growth Has Been Rapid

These health centers enlarged their field of activity gradually and new centers were created. At Warsaw, for instance, in a short time, six new centers were organized, and if the plan laid out by the health department of this city is followed, there will be fourteen such centers in two years. Just outside of Warsaw there are at this time nine centers. The Skierniewice district has four and the Bendzin district, four.

The idea of health centers has spread rapidly through Poland. On January 1, 1929, there were 140 in all, of which 74 were divided into two parts —child health and antituberculous; 43 have three special divisions and 23 have more than three.

The listing points out the extent to which these health centers have tended to spread all over Poland. The most important and best organized centers, like Mokotow, some in Warsaw, Skierniewice and Bendzin, have become objects of study by health workers and social workers who wish to found similar centers. These centers also serve in the training of students from the state health school and from the nursing schools.

How the Centers Function

Doctor Kacprzak says, "In our conception, each health center is made up of several clinics, united not only by their administration but also by their aims and their method of functioning. The patient always deals with the center, not with the special clinic; he is admitted to a control bureau and is put under the care of the visiting nurse, depending on the district in which he lives."

As was said before, the extent of activities of the centers varies in each locality, but each center is supposed to give prenatal care, child health and antituberculous care. Many of the centers have an antivenereal section, an antitrachoma section, or a dental section. Many are working against alcoholism or malaria. School health is undertaken.

Under the auspices of several centers, bath establishments have been opened, popular laundries, day sanitariums for weak children and gymnasiums.

The centers of the big cities and their neighborhoods are served by several specialists. The rural centers have only one doctor in charge of all med-

[1] Kacprzak, M., *Centres d'Hygiène en Pologne*, Varsovie, 1928.

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CONVALESCENT-ITIS!

THE SYMPTOMS of "convalescent-itis" are: grouchiness, ill-temper, irritation, restlessness, indignation. To visitors and members of the family it proves contagious. And the sad effects are suffered—not by the patient, but by the hospital! This strange, wide-spread malady has been successfully treated in many great hospitals.

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ical activity. The clinics are managed in a way to prevent any possibility of contagion. If the local conditions do not permit any separation of the patients in the waiting room or in the doctor's examining room, different hours for consultation are given for patients with different diseases.

Besides the doctor who works in the center, even in the centers that boast only one doctor, there is a visiting nurse. She is charged with all the social work of the district, the care of the sick and visits to their homes.

Adapting the Center to the Community

"The center is only a point of contact with the community; the real work is done in the family. The number of home visits is the best indication of a center's activities, because the greatest success, from the point of view of preventive medicine, can be attained only by changing the patients' manner of living." If one center has more than one nurse, the territory served is divided into sections and each nurse is given a section. This plan is less costly and better adapted to the needs of families in the districts and makes the specialization of nurses unnecessary.

More and more there is a tendency here to turn over to the health centers new duties in the fight against acutely infectious diseases and to charge them with duties that formerly belonged to the sanitary board, such as the health and cleanliness of the neighborhood. For this purpose, the health departments of the large cities appoint a sanitary controller similar to the sanitary inspectors in England to certain of the health centers. Special training is given them in the health school maintained by the state.

The health centers use several means for disseminating active health propaganda. Some use regular courses and some use lectures. The doctor in his consultation hours and the visiting nurse in her home visits are invaluable in the work. From time to time the health center will arrange a film or radio lecture, parties for children and their parents or Christmas parties, with the sole aim of obtaining the confidence of the citizens and teaching them to regard the center as their own institution.

Health Centers and Social Insurance

In principle the health centers avoid any treatment by drugs, except in venereal infections, trachoma and some other diseases where such treatment is the only means of overcoming the disorder and of protecting the neighborhood from contagion.

For the best possible working of these centers, the work of the center must be combined with that of organizations dealing with social insurance. The minister of work and of social insurance has expressed his desire to arrange this, particularly in the villages and in the country. It is therefore hoped that the defect which slows up the best functioning of the health centers and causes a dissipation of effort, will soon be corrected.

The creation of the health centers was halted at the start, not only by financial difficulties but also by technical factors, such as lack of good locations or well qualified personnel. To smooth out these difficulties, the health department began a course in architecture to make plans for different types of health centers—in the large city, the small town and the rural community. The result was encouraging and started real progress in the building of health centers. A special plan of founding the health centers in shower bath establishments in the rural mountain communities was worked out by the state health school. This was done on the initiative of the central relief committee for flooded regions in the southeast. Three centers of this type will be started this year, financed by the central relief committee, in the mountain regions of Stanislawow and Lwow. In view of the great obstacles to communication in these regions, these special centers will have small dependent stations with a nurse in charge in the distant localities lost in the mountains.

On the other hand, Warsaw has had a special clinic planned which will be adapted to the needs of a capital city.

An Urgent Problem

One of the most urgent problems in the future spread of this health center movement is that of personnel. The state health school has organized a special course this year for the physician-directors of health centers for whom the preparation given at the universities in social hygiene and preventive medicine is not adequate.

The school has at the same time begun a course for the training of visiting nurses, destined to work in rural health centers. It is absolutely necessary to complete the training given in the nursing schools, of which Poland has six, by special studies, theoretical and practical, in social hygiene, since the actual program of most nursing schools emphasizes hospital work.

Each year the state health school gives a four to five-month course for the training of sanitary controllers.

In this manner it is hoped to obtain without great delay personnel well enough qualified properly to conduct the health centers.

The expenses of construction and maintenance are provided by the city or by the civil authorities.

In the country districts part is provided from the sickness insurance funds; the state also grants certain subsidies to these institutions by way of encouragement.

The centers tend to coordinate all efforts, the ultimate aim of which is the bettering of sanitary conditions, government, community, social insurance organizations and benevolent societies. Seen in this light the center is the smallest sanitary unit burdened with all the problems of public health and social work in its region. In the most important section of each district, a completely equipped health center is created, under the direction of the doctor in the district whose rôle is to watch over and coordinate the work of all the local health centers. It is satisfying to note that the sanitary organization of the district of Tarnopol, for example, under the direction of Doctor Salak, has created nineteen health centers in its territory. If the development of health centers continues as rapidly as at present, it can well be believed that the country will be covered with a serrated network of such institutions, dealing with all the problems of public health and preventive medicine. When this plan is realized, the sanitary organization of Poland will be definitely established on a solid, practical and rational basis that will safeguard the country's health.[1]

POLISH HEALTH CENTERS ACCORDING TO DEPARTMENTS

Departments	*Numbers of Health Centers*
Varsovie (town)	7
Varsovie (district)	21
Lodz	13
Kielce	15
Lublin	7
Bialystok	8
Wilno	2
Nowogrodek	3
Polésie	3
Wolhynie	2
Poznan	9
Pomeranie	0
Silésie	8
Cracovie	10
Lwow	4
Stanislawow	9
Tarnopol	19
Total	140

[1]Adapted from a report by W. Chodzko, former minister of public health, director of the state school of hygiene, to the committee of the International Office of Public Health: excerpt from the weekly *Bulletin de l'Office Internationale d'Hygiène Publique*, vol. 21, 1929, Fasc. No. 9.

Should a Family Pay More Than It Can Afford for Hospital Care?

A comment on the article, "What 536 Chicago Families Spent for Illness," by Margaret Lovell Plumley, research assistant, Julius Rosenwald Fund, Chicago, in the March issue of THE MODERN HOSPITAL, comes from Harriett S. Hartry, superintendent, St. Barnabas Hospital, Minneapolis.

"I have just read the story of the Matthews family as told by a research worker of the Julius Rosenwald Fund on page 140 of the March number of THE MODERN HOSPITAL," writes Miss Hartry.

"Mr. Matthews paid $895 for hospital, physician's and nurses' fees for one of his three children who was suffering from osteomyelitis. The items of expense as given, however, amount to $817. Of this amount $416 was for day and night special nursing.

"The average child in such a case will do very well in a public ward and on student care, in which case the doctor's bill, while not excessive, would doubtless have been less.

"Would it be too much trouble to ask the field director responsible for this data to explain the seemingly unnecessary expense in the care of this child whose father's income is, as stated, $2,345 a year?"

Explaining the Situation

In reply to Miss Hartry's comment, Miss Plumley offers the following explanation:

"First, the difference between the $895 given as the total amount expended and the $817 hospital expenses is $78. The $78 unaccounted for was spent as follows: $12 for twenty-eight trips to the clinic; gauze and alcohol for the patient, $16; transportation for the father and mother during the eleven months the patient was in the hospital, $49.56.

"The reasons why are another matter. These were not investigated in the study. The facts on the schedule showed that the patient was in the hospital most of the time during the year considered. He was brought home once for a short time. Probably, however, the family did not realize when he was first taken to the hospital that he would be obliged to stay there so long. They probably wanted to give their child the best care possible.

"The schedule does not tell us why the patient was put in a private room and given special day and night nursing. It may have been (1) because they wished to give their child the best of care regardless of the expense and the burden of debt they were incurring; (2) the doctor may not have known their circumstances and may have suggested

the private room; (3) the hospital may or may not have suggested other alternatives. These are only conjectures. We do not know the facts.

"We do know, however, that at the end of the four weeks the family had incurred a hospital bill of $152 and had paid the special day and night nurses $416. Is it not likely that a family obliged to borrow as they were would have requested a day and night special nurse unless the doctor and hospital had thought this necessary?

"The family next paid $49 for two weeks' ward care of the patient. After that the hospital took care of him free of charge. The expenditures for the clinic trips, gauze and alcohol must have been incurred either before the patient first went to the hospital or during the brief interval when he was taken home.

"There is, as you appreciate, a very strong dislike on the part of some people to put their relatives in a ward. Rightly or wrongly, they frequently feel that neither the care nor the food is as good as if a patient were in a private room. A mother, too, frequently fears leaving her young child—this patient was only eight years old—to nurses who may or may not treat him with the tenderness that she would. She may be willing to sacrifice almost anything to have her child where she can be with him all day long, as one usually can in a private room, instead of for short intervals. Whether a heavy sacrifice for this purpose is wise or necessary is another matter. Certainly many parents feel that way.

"The case was put in as illustrative of some families who had paid more than they could afford to the hospital. I believe it proves its own point.

"It might be pertinent to ask Miss Hartry just how frequently a hospital admitting clerk suggests to a patient who comes in to take a private room that he go to a ward instead, or how often the floor nurses persuade the family not to engage special nurses if the child in a private room is seriously ill and lack of special nursing would mean that the floor nurses would have to devote an undue amount of their time to his care."

New Rule for Interns in Mental and Tuberculosis Hospitals

Two years' service on the staff of an approved hospital for tuberculosis or for mental disease will be accepted in place of the present requirement of a one-year rotating internship in a general hospital, under a new rule passed by the Michigan State Board of Registration in Medicine. This plan will make it possible for a physician who intends to limit himself to these specialties to begin his chosen work immediately after graduation.

One of the unusual photographic effects in the all-talking screen version of Fannie Hurst's popular novel, "Lummox." Courtesy of United Artists.

All night long the soggy swish of scrub brushes, the rancid odor of water-flooded floors — everywhere pools of oozing dampness.

● Troops of weary women have been taking part in such midnight performances night after night—year after year. Countless buildings—offices, banks, institutions—have furnished the setting. With pathetic realism the performers have played their parts, as best they could, in the ineffectual battle with dirt and grime.

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(Continued from page 120)

ent, Mt. Sinai Hospital, Milwaukee; S. Margaret Gillam, director of dietetics, University Hospital, Ann Arbor, Mich.; Leota E. West, dietitian, Ravenswood Hospital, Chicago; M. Ray Kneifl, executive secretary, Catholic Hospital Association.

Gladys Brandt will preside at the luncheon meeting, at which Dr. Edward A. Fitzpatrick, dean, graduate school, Marquette University, Milwaukee, will be the principal speaker.

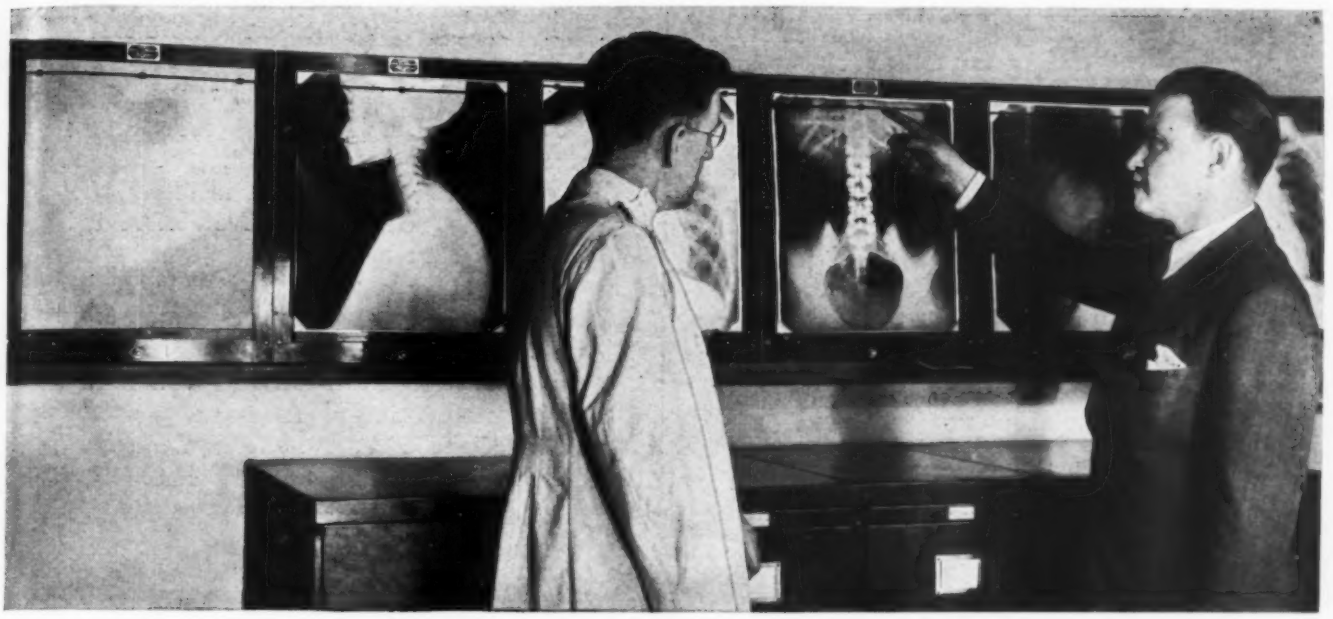
Those who will appear on the afternoon program are Dan Traner, superintendent, Swedish American Hospital, Rockford, Ill.; Dr. James L. Smith, superintendent, Illinois Eye and Ear Infirmary, Chicago; Adeline M. Hughes, superintendent, Passavant Memorial Hospital, Jacksonville, Ill.; Maurine Wilson, record librarian, Ravenswood Hospital, Chicago; Adda Eldridge, director, bureau of nursing education, State of Wisconsin, Madison; Sister Helen Jarrell, superintendent of nurses, St. Bernard's Hospital, Chicago; Babette Jennings, director, social service department, Children's Memorial Hospital, Chicago; Margaret Johnston, superintendent, Beloit Municipal Hospital, Beloit, Wis.

National Health Council Moves Into Larger Quarters

With the expansion of the work of the National Health Council, which recently celebrated its tenth anniversary, and the development of numerous activities among its fifteen constituent members, the council on April 1 is moving into larger quarters. On that day the address will be the new Nelson Tower Building, 450 Seventh Avenue, New York City, instead of 370 Seventh Avenue.

The National Health Council and its member organizations will occupy the eleventh to the fifteenth floors, inclusive. These organizations include: American Child Health Association; American Heart Association; American Public Health Association; American Social Hygiene Association; National Committee for Mental Hygiene; National Organization for Public Health Nursing; National Society for the Prevention of Blindness; National Tuberculosis Association; Foundation for Positive Health.

Space in the same building has been contracted for by the National Social Work Council, a cooperative group of twenty-two national social agencies, and by the following other organizations: American Journal of Nursing; American Nurses' Association; Committee on Grading of Nursing Schools; National Health Circle for Colored People; National Amateur Athletic Federation (Women's Division); National League of Nursing Education; National Probation Association; New York State Nurses' Association.



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For a quarter hour of stimulating entertainment, tune in on "Devils, Drugs, and Doctors," broadcast each Sunday evening at 8 o'clock, New York time, over a coast-to-coast network of the Columbia System. These talks, sponsored by Eastman Kodak Company, are given by Dr. Howard W. Haggard, Associate Professor of Applied Physiology, Yale University.

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Dr. C. C. Burlingame Heads Historic Psychiatric Hospital

Dr. C. Charles Burlingame has moved his professional offices from New York City to Hartford, Conn., where on April 1 he assumed his duties as physician-in-charge of the Hartford Retreat, with residence in West Hartford.

Doctor Burlingame was for eight years in the psychiatric service of the state hospitals of Massachusetts and Minnesota. More recently he served as executive officer of the joint administrative board in charge of the organization and development of the Columbia-Presbyterian Medical Center, New York City, since which time he has been engaged in psychiatric practice.

The Hartford Retreat is the third oldest privately endowed hospital for mental diseases in the United States, having been founded and chartered by the Connecticut State Medical Society 109 years ago.

Central Council for Nursing Education Moves Office

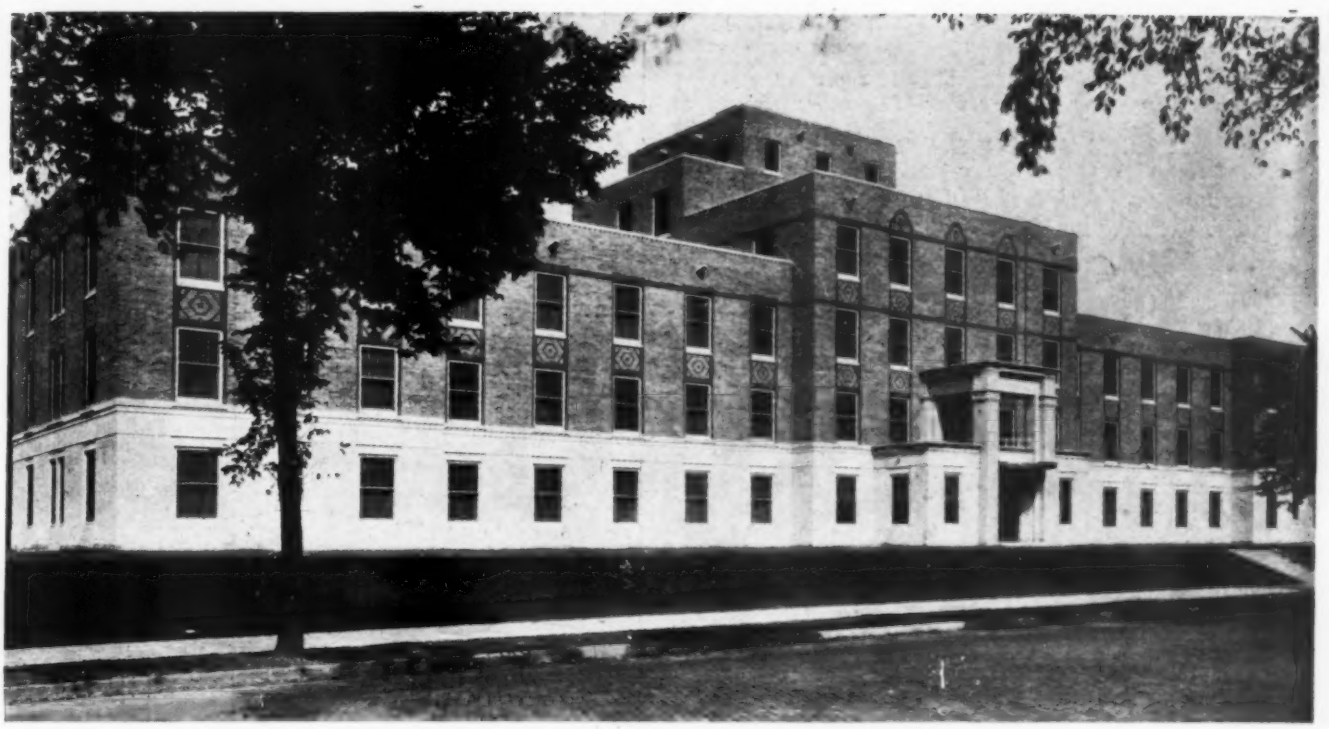
The Central Council for Nursing Education, Chicago, has changed its address from 8 South Michigan Boulevard to 1520 Willoughby Tower Building. The change was effective April 4.

Lectures in English to Be Given in Paris Hospitals This Summer

The Faculty of Medicine of Paris (the medical school of the university) announces that, during June and July, 1931, a comprehensive series of postgraduate courses will be presented. The enterprise is conducted under the auspices of the Association for the Development of Medical Relations—the "A. D. R. M."—a commission sponsored by the French government.

The work will be presented in the English language. Clinics, lectures and demonstrations will be conducted in the great hospitals of Paris, on a wide variety of topics, by the most eminent French clinicians. A nominal fee will be charged for each course. Upon the completion of each course, the student who qualifies will receive a certificate covering the work, signed by the professor in charge.

Detailed information may be secured by addressing direct, Professeur E. Hartmann, president, "A. D. R. M.," Faculty of Medicine of Paris, 12, Rue de L'Ecole de Médecine, Paris (6e) or, in the United States, Dr. Frank Smithies, 920 North Michigan Avenue, Chicago.



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Nursing League Program Promises to Be Interesting

A six-day program that promises to be interesting and helpful is that planned by the National League of Nursing Education, which is meeting this year in Atlanta, Ga., May 4 to 9.

Speakers on the program will include Elizabeth C. Burgess, president of the league; Dr. C. W. Roberts, Atlanta; Evelyn Childs, Western Reserve University school of nursing, Cleveland; Effie J. Taylor, Yale University school of nursing; Edna Newman, Cook County school of nursing, Chicago; Catherine Bastin, University of Oregon; Eva Caddy, president, New Jersey League of Nursing Education; Mary Emma Smith, National Society for the Prevention of Blindness; Dr. W. H. Burton, professor of education, University of Chicago; Dorothy J. Carter, assistant director, National Organization for Public Health Nursing.

The entertainment schedule that is being arranged by the Georgia hostesses will include a choir of Negroes giving an evening's program called "Heaven Bound."

City Grants $500,000 to Montreal General Hospital

The city council of Montreal, Que., has approved a grant of $500,000 to the Montreal General Hospital, payable in twenty years, to help the hospital meet the interest charges on its debt, which amount to $40,000 a year. This represents an annual subsidy of $25,000 a year over a period of twenty years.

Pennsylvania to Build Two New Hospitals

Announcement was made recently by Dr. Theodore B. Appel, secretary of health for Pennsylvania, that he had approved plans for the construction of a 100-bed tuberculosis hospital unit to be erected by the county commissioners of Delaware County at Delwood, Pa.

This hospital will have a capacity for 100 adult patients and is part of the general program looking toward additional hospitalization in the respective counties for tuberculous patients.

It was also announced by the secretary of health that plans have been approved for the construction of a tuberculosis hospital in Berks County. This institution will be six miles northwest of Reading, and will have a capacity of 100, fifty beds being set aside for adults and fifty for children.

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There is a group of men—good men, too—whose services you need. They will work for you without charge. You can call on them at any time. They will see to it that the supplies you use are the finest in the world—yet inexpensive.

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New Duke Hospital and Medical School Is Dedicated

Formal dedication of the Duke University school of medicine and the Duke Hospital was held on April 20 at the university in exercises attended by distinguished representatives of the medical profession from many leading American institutions.

Built and equipped at a cost of approximately $4,000,000, the huge structure is regarded as one of the most modern buildings of its kind in America.

Among the speakers who took part in the dedication exercises were Dr. David Linn Edsall, dean, Harvard medical school; Dr. Lewis Hill Weed, director, Johns Hopkins school of medicine; Dr. William Henry Welch, Johns Hopkins; Dr. Watson S. Rankin, Charlotte, director of the division of hospitals of the Duke Foundation; Gov. O. Max Gardner of North Carolina, and Dr. Thurman D. Kitchen, Wake Forest College, representing the medical profession of the state.

George G. Allen, New York City, chairman of the board of trustees of the Duke Foundation, made the formal presentation of the building at the morning session, and Col. John F. Bruton, Wilson, chairman of the university board of trustees, accepted the building in behalf of that group.

Chicago Offers Summer Courses for Graduate Nurses

Courses in nursing to be offered to qualified, registered graduate nurses during the summer quarter 1931 at the University of Chicago include the following: supervision in schools of nursing; methods of teaching the principles and practice of nursing; administration in schools of nursing.

For information concerning admissions, the university examiner should be addressed. The general correspondence bureau should be addressed for other information. Anna D. Wolf, R.N., A.M., is the associate professor of nursing at the university.

Chicago Dietitians Hear Speech on Meat

The March meeting of the Chicago Dietetic Association was held on Wednesday evening, March 18. Erna Bertrams of Armour and Company spoke on the subject, "What the Dietitian Should Know About Meat."

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Hospital Librarians Asked to Join National Association

The Association of Record Librarians of North America is anxious to extend the privileges of membership in the association to record librarians in all approved hospitals, according to Maurine S. Wilson, chairman, membership committee. Any librarian who is interested may obtain application blanks from the librarian on the membership committee who lives nearest to her.

The committee is made up of the following librarians: M. Beatrice O'Connell, St. Francis Hospital, Hartford, Conn.; Mabel C. Root, Mayo Clinic, Rochester, Minn.; Elizabeth Cook, Hospital of the Good Samaritan, Los Angeles; Bille Haag, Baptist Hospital, Houston, Tex.; Maurine S. Wilson, Ravenswood Hospital, Chicago.

Flower Hospital Receives $17,500,000 From Wendel Estate

Flower Hospital, New York City, is to receive $17,500,000 as its share in the estate left by Ella V. Von E. Wendel, eccentric recluse, who died recently. The will of Miss Wendel designated that Flower Hospital should receive thirty-five parts of the 200 parts into which her $100,000,000 estate was divided.

Five Chicago Hospitals to Combine

Under the direction of Dr. Harry O'Connor, five hospitals in Chicago will be operated as one. The hospitals in this combination are the Rogers Park Hospital, Garfield Park Hospital, Franklin Boulevard Hospital, West Lake Hospital, and Welles Park Hospital.

A Plan of Retiring Allowances for Employees

A plan of retiring allowances for hospital employees, as worked out by a special hospital pension committee, assisted by the secretary of the Carnegie Foundation for the Advancement of Teaching and by the general director of the United Hospital Fund, is now available through the Hospital Information and Service Bureau, United Hospital Fund, 151 Fifth Avenue, New York City. The committee made a close study of the subject for more than a year, and the report presented is the most comprehensive and detailed study of a plan for the retirement allowances of hospital employees that has yet been submitted.